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PROTECTION OF LIFE

medical treatment and criminal law

Working Paper 26

Law Reform Commission
of Canada

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MEDICAL TREATMENT AND CRIMINAL LAW

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Notice

This *Working Paper* presents the views of the Commission at this time. The Commission's final views will be presented later in its Report to the Minister of Justice and Parliament, when the Commission has taken into account comments received in the meantime from the public.

The Commission would be grateful, therefore, if all comments could be sent in writing to:

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Introduction

This Commission's Protection of Life Project has been designed to examine some of the most controversial issues in biomedicine, including the definition of death, sterilization, human experimentation, the cessation of treatment, and behaviour modification. In the background to many of these issues lies the fundamental question as to the position of medical treatment in the present law and, in particular, the *Criminal Code*. This Working Paper is intended to form a "backbone" of criminal law analysis and provide a legal theory within which the more specific and controversial issues can be discussed.

The impact of criminal law on the administration of treatment is largely overlooked in the Canadian context. Potential criminal liability is rarely considered by doctors and hospitals when seeking consent to or waiver of treatment. The handful of prosecutions in the last fifty years, as compared with the increasing frequency of civil litigation suggests to some that the *Criminal Code* is ineffective in this area because the type of harm contemplated in the administration of treatment is not of the degree to warrant the intervention of the criminal law. Indeed, the risk of criminal liability has been said to be more the "product of a fertile legal mind than a realistic possibility".[1]

The Law Reform Commission nonetheless realizes that the lack of prosecution in this area does not suggest the inutility of an examination of the present criminal law. In fact, the exercise of prosecutorial discretion in this manner may indicate a gap between contemporary values and those reflected in the *Criminal Code*. This is especially cogent when one considers that the present provisions of the Code which specifically relate to medical treatment were enacted in 1892, when many medical procedures were regarded as highly dangerous and questionably

therapeutic, and the medical profession was in its founding organizational stage.

Despite the age of the Code's provisions, a comprehensive study of potential criminal liability for the administration of treatment had not yet been undertaken. Not only was such a study important to the Protection of Life Project, but it was necessary to answer questions from the medical world as to its position in relation to the *Criminal Code*. A preliminary examination revealed an anomaly between a plain interpretation of the Code and contemporary medical practice, particularly in the terminal treatment situation. Furthermore, the Commission was aware that the few cases which had discussed the issues, had served mostly to confuse and complicate the more general provisions of the Code.

The need for clarification of the criminal law position with regard to treatment is further heightened by competing claims as to the appropriateness of the criminal law at all in dealing with these matters. Medical doctors express dissatisfaction that the practice of medicine falls within the offences against the person, and suggest that the social utility of treatment and the therapeutic motives of doctors should be recognized. On the other hand, however, commentators have suggested that the large damage awards given by juries in civil cases indicate societal concern with malpractice and the desire that this activity be dealt with by criminal sanction, rather than being borne by society through higher insurance costs.[2]

Over all of these considerations, the Commission appreciated that the criminal law provides a basic system of fundamental values to guide human activity and is thus a likely instrument to reflect contemporary social thought on biomedical issues. There was concern that advancing technology providing control over life and death, could be dictating the prerequisites to treatment, rather than treatment being decided on the basis of individual rights within a context of social review.

In response to all of these considerations, this Working Paper undertakes a basic examination of the content and policy of the present criminal law as it relates to medical treatment. It

then attempts to evaluate that policy in light of modern thought and development.

Part I, "The Perspective of the *Criminal Code*: Binding Principles", is an examination of the essential commitment in the Code to the fundamental value of the preservation of life and health and the maintenance of dynamic, responsible, and free health professions. Other integral values are briefly discussed.

Part II, "The Legislative Framework", is an outline of the present structure of the *Criminal Code* pertaining to medical treatment and the implications of this arrangement. The criminal laws of other jurisdictions are also noted.

Part III, "Treatment and Our Present Criminal Law", provides a thorough analysis of the present scope of criminal liability for medical treatment. Because of the utility of this legal study for medico-legal education, it has been inserted in its entirety. However, it is suggested that a reading of the summary may suffice for those who are not interested in the fine details of the law.

Part IV, "Considerations and Limitations of the Present *Criminal Code*", attempts to evaluate the present law as it applies to the issues of the criminality of treatment, the concept of treatment itself, consent and refusal of treatment, the emergency situation, and practice by the qualified and unqualified. The discussion of each of these issues leads to specific conclusions or recommendations.

Finally, Part V, "Proposed Solutions and Suggested Reform", summarizes the tentative conclusions and recommendations of the Commission. Alternative models to implement reform are discussed and draft legislation presented.

This Working Paper does not represent the final view of the Law Reform Commission on these matters. However, it is put forward to stimulate public discussion and response on the important aspects of medical treatment as it affects individuals. Because the paper deals with the criminal law, primary concern

is with gross conduct in the treatment environment causing injury to health or life or constituting an attack on the fundamental principles which the *Criminal Code* seeks to protect. It should, therefore, be kept in mind that the criminal law protects society only against public wrongs. It is not concerned with private wrongdoing, unless it becomes a matter of public concern.

PART I

The Perspective of the Criminal Code: Binding Principles

Criminal law relating to treatment performs dual functions: it protects both the individual and society from harm and it reaffirms fundamental social values.[3] Both functions aim at the punishment of behaviour which threatens or harms public interests. These interests are not absolute and may conflict and change with time. In the consideration of treatment, protection involves preservation of life and health for an individual, and protection of those performing these vital acts for society. Among the fundamental values affirmed are sanctity of life, security and liberty of the person, self-determination, human dignity, freedom of religion and privacy.

The operative mode of effecting these dual functions is through the creation of specific offences, duties, and defences. Together, these indicate the acceptable standard of conduct for a particular kind of act. The value asserted in an offence, duty or defence, reflects public policy at the time of enactment. However, the ultimate social sanction comes later in the prosecution and punishment of individual acts.[4]

1. Affirmation of Fundamental Values

The affirmation of fundamental values is an integral function of the criminal law not only for the elucidation of the values themselves but also for expression of the tolerable limit which

society will withstand or expend in order to preserve the social fabric. Many of these values are also reflected in the *Canadian Bill of Rights*. The criminal law provides a method of enforcement of individual fundamental rights,[5] based on the balancing theory which preserves individual freedom to the extent that it does not constitute a clear and present danger to society.[6] While the preservation of values may be the ideal, criminal law must yet be precise and practical to achieve the desirable results.

The *Criminal Code*, broadly speaking, reaffirms the principles of freedom, human dignity and social justice. The Code safeguards the traditional values of sanctity of life, security and liberty of the person, self-determination, human dignity, freedom of religion and privacy. In addition, the contemporary values of health care itself, free choice of employment, free flow of information, children's rights, and participation to social progress and development have a certain significance in relation to criminal law. For present purposes, it is important only that these values be enunciated as the ideal to which the criminal law must respond when it evaluates the often competing interest of individual and society in the giving of treatment.

2. Preservation of Life and Health

The *Criminal Code*'s function of preserving life and health is protective of the fundamental right of an individual to the security of his person. This right was said by Blackstone in 1753 to be the first regard of English Law[7] and was declared as the first right of the *Canadian Bill of Rights*.[8] The right to security of the person means not only protection of one's physical integrity, but the provision of necessaries for its support. The provision of necessaries may be translated into the modern right to medical care as enunciated in the *Universal Declaration of Human Rights*.[9]

Before attempting to delineate the concept of health in the *Criminal Code* two things must first be considered: the implications of the uses to which a concept of health can be put and

the definition of health provided by the World Health Organization.

The concept of "health" is used in the Code to delimit offences, duties and defences which tend to the protection of the body of an individual. The application of force to the body of another is limited by the requirement to do or not to do something which may affect that person's health. Conversely, the law's condoning of an act done for someone's health signifies that there are limits to the rights of the person acted upon. Thus, a concept of health in the Code may either legitimize or render illegal actions which fall within or without the meaning. Through legitimization, the Code sanctions acts which may otherwise be contrary to individual's wishes or rights because of a perceived higher societal value.

The World Health Organization's definition of health as . . . "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*" continues to spark lengthy debate despite its 1946 origin. Those general terms of wide public use have ethical, social and political implications and their reach extends to every element of human happiness.[10] The concept of "social well-being" far exceeds the meaning presently contemplated in Canadian criminal law for it includes political injustice, economic scarcity, food shortages and unfavourable physical environments.[11] All human misfortunes and disorders are not forms of illness from which one must be saved under the rubric of health in the criminal law. Obesity, cigarette smoking and alcoholism, to name only a few factors, may all be included within a concept of health; but moral or righteous judgments involving health as an ideal should not replace health as a norm involving the deviation from standards of organic and behavioural function, at least for purposes of criminal law.

A limitation of "health" to physical and mental conditions not only reflects the traditional concept as normally understood, but it represents the limits already recognized in law. (. . . For purposes of discerning what the law actually recognizes, however, the true intent of the legislator as expressed in legislation must be discerned along with the authoritative interpretation of

that legislation.) Mr. Justice Dickson in *Morgentaler v. The Queen* commented that "The values we must accept . . . are those expressed by Parliament . . ."[12] and not those of the extreme partisans in the great debate on abortion. (The reasons written by Mr. Justice Dickson were adopted by the majority of the Court in that case.) Although due concern for the health of a person is expressed more than once in the *Criminal Code*, the thrust of the majority's reasons indicate that not every assertion of danger to health will avail to satisfy the law's concerns. Indeed, he adopted an expression of grave doubt that even a threat of suicide (although none was made by the patient in that case) would in itself be sufficient to legalize surgical, chemical or other treatment which the law forbids.

Nevertheless the notion that health, in law, includes not only physical health but also mental health, has been articulated in some English jurisprudence[13] and by some legal academic writers.[14] It may be observed that "health" is not only so inclusive but also so limited. This limitation apparently leaves out social and family health, eugenic health, and ethical health, all of which were recognized components of "health" as understood by some of the medical profession in interpreting the abortion provisions of the Code.[15] The Supreme Court of Canada adopted the view in *Morgentaler*, that the abortion provisions create a comprehensive code without outside application or intrusion[16] and it would seem therefore, that whatever interpretation is given to "health" for that purpose, it is confined to those provisions. The non-prosecution of some abortion cases may however indicate local prosecutorial toleration of a more extensive notion of "health" than physical and mental.

Thus, for the purpose of the criminal law, "health" should be a state of physical and mental well-being. Such a state of well-being, in law, ought first to be notionally sufficient to cope with the ordinary living in modern society, but does not carry a guarantee of stress-free, non-responsible life-style, because stress as well as responsibility for one's behaviour are incidents of living in society.

Second, that state does not need to be "complete" but must be adequate so as to avoid significant impairment of physical or

mental function.[17] The concepts of social, family, ethical and eugenic well-being have a place in this formula insofar as they are often closely linked with emotional and other conditions which may in turn reflect themselves in physical or mental problems. In this respect, "health" is not confined to strict medical concepts but focuses on the condition of a particular individual in a particular case.

The function of the Code in this regard is to preserve life and health. Preservation includes maintenance of present states of life and health and protection from harms, evils, or injury according to the usual legal meaning.[18]

3. Protection of Those Performing Vital Acts

The *Criminal Code* protects some acts which might otherwise be criminal, harmful to society because they are productive of a social value. Such acts are categorized as the administration and enforcement of law,[19] the protection of property or person,[20] and the protection of persons in authority.[21] It is the last category of "protection of persons in authority" which warrants specific attention within the context of treatment.

Persons in authority within the meaning of the present *Criminal Code* include a parent or schoolteacher in the discipline of a child,[22] the master of a ship in the maintenance of discipline on a vessel,[23] and everyone in the performance of a surgical operation.[24] Although the Commission is of the view that surgical procedures are indeed a vital social activity worthy of distinction and justification in the *Criminal Code*, it is difficult however to justify a surgeon's position as authoritative. This is made clear by a brief examination of the origins, meaning and limits of the concept of "authority" in the *Criminal Code* and the nature of the doctor-patient relationship.

Unlike parents, schoolteachers and masters of ships, those administering treatment are not, at common law, under a duty to take action in case of danger.[25] They fall under the normal

rule that a person has no duty to protect others unless he has directly or indirectly undertaken to do so.[26] It is not surprising that those specifically required to act would be protected from criminal liability provided the act was performed reasonably. This rationale is not directly applicable to surgical interventions.

The concept of authority, both in its natural and legal meaning, implies control, usually of a disciplinary nature, over someone committed to one's charge.[27] It is often considered synonymous with power.[28] Medical personnel are not legally regarded as persons in authority in the sense of control. Physicians and psychiatrists are generally not accepted as persons in authority for the evidential purpose of confessions because they do not have any control over the accused.[29] Neither are doctors considered representatives of a patient so as to have control in an emergency situation.[30] Although the nature of the doctor-patient relationship varies according to the mode of interaction, not even the complete helplessness of some patients,[31] imputes to the doctor a position of legal authority.

There is a degree of unreality about the theory of authority if one considers the purposes of criminal legislation in relation to medical treatment. The protection given to persons performing certain surgical procedures recognizes the value of the service to the patient and the necessity for maintaining a dynamic and free medical profession. Lord Ellenborough wrote in one of the earliest medical liability cases: "if you find (him) guilty of manslaughter, it will tend to encompass a most important and anxious profession with such dangers as would deter reflecting men from entering into it."[32] The American Model Penal Code of 1962 saw the issue as one of responsibility so that those entrusted with the special care of persons could perform their duties under the social sanction of justifiable risk.[33]

One rationale for considering surgeons as persons in authority is based upon their vicarious liability in common law for all acts performed in the operating room according to a "captain of the ship" analogy. By this theory, the surgeon is in charge of an operation and, therefore, has the right to control all activities associated with the procedure. The increasing tendency, however, is to allocate responsibility among the professionals

involved in the various tasks during the procedure according to the degree that they exercise independent judgment.[34] Adherence to the former theory thus ignores the realities of modern medicine.

Finally, some sociological theory reflects the notion of doctors as authoritative because of their professional status and the changed role of an individual when sick. This fails to appreciate the doctor-patient relationship as a bargaining process between interests[35] and as a contractual obligation between equals.

Any protection related to treatment in the Code should recognize the performance by professionally skilled, responsible persons of acts necessary to both the individual's and society's well-being. Just as the *Criminal Code* enunciates diverse values in the nature of offences, so it affirms many varied concepts of protection which must be recognized for the diversity of values which they represent.

PART II

The Legislative Framework

The construction of criminal legislation by means of offences and defences has particular meaning. To describe an act as a crime at all is, first, to render it an unlawful act.[36] In this way, the inclusion of one specific activity within a kind of conduct which is criminal, is to characterize the specific activity as potentially criminal. Whether it will, in fact, ultimately be found to be criminal depends on the presence of certain conditions concerning justification or excuse to the particular activity in question. Thus, the legality of a particular course of conduct is indicated both by the elements of offences and by the applicable defences, taken together.

The characterization of conduct as either an offence or a defence directly relates to procedural matters at trial. All the conditions required to constitute an offence must be proved by the prosecution in order to convict. If the accused's conduct falls within the specific provisions of a defence, the accused should raise these conditions after the prosecution has discharged its burden of proof in regard to the offence.

When dealing with treatment, the framework of construction most commonly used in criminal legislation is to allow treatment to fall within the kind of offences characterized by an application of force upon the body of another. A specific defence may then be available to exempt certain forms of treatment under certain conditions.

In this section, the Commission focuses on this problem within the legislative framework of the Canadian *Criminal Code* and examines alternative approaches from other jurisdictions.

1. The Framework of Our *Criminal Code*

The basic framework of the Code is unchanged from the common law position whereby all applications of force upon the body of another are considered to be crimes unless there is legal justification.[37] Thus, medical treatment is not considered to be different from other applications of force, in the absence of specific legal justification. In the *Criminal Code*, therefore, medical treatment falls within the offences against the person such as assault, assault causing bodily harm, causing bodily harm with intent, criminal negligence causing bodily harm, criminal negligence causing death, manslaughter and even murder. Based on established methodology, the Code then provides in section 45 legal justification for surgical procedures in the form of a specific defence:[38]

> Every one is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if
>
> (*a*) the operation is performed with reasonable care and skill, and
>
> (b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

This section creates a defence providing justification in cases of surgical operations upon the fulfillment of certain criteria. It appears to codify the criteria developed at common law to legalize surgery, except for the element of consent. The absence of consent implies that this section covers the emergency or necessity situation, but creates uncertainty of ultimate legality. This situation is traceable to the origins of the section.

Section 45 is almost identical[39] to the early British Draft Code of 1880.[40] Stephen, the drafter, accepted the proposition in law and, further, specifically provided that a person could consent to bodily injury for surgical purposes.[41] This latter provision, however, was left out of our *Criminal Code*, presumably because the offence of assault includes the element of lack of consent of the victim. No problems arose until *R. v. Donovan*, in 1934, which established that one could not consent to bodily harm and that "bodily harm" includes any injury interfering with health or comfort that need not be permanent but must be more than transitory.[42] This created a gap between the extent

of the justification in section 45 and the limits of surgical interference to which a patient would consent.[43] While the substantive considerations involved here will be discussed below, it is sufficient to note that section 45 creates a defence which has certain implications for trial procedure and whose limitations create uncertainty as to the ultimate legality of some medical treatments.

It has been suggested that the Code has decided the ultimate legality of medical treatment by the wording of section 198, creating a legal duty for those undertaking to administer treatment. This section appears to presume the non-criminality of treatment upon a plain reading of the words. It says:

> Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

However, this section, unchanged since the first *Criminal Code* of 1892,[44] is based on the idea that those going about their lawful occupations wherein danger may probably arise to others must first possess and then exercise reasonable knowledge, skill and care in so doing.[45] The lawfulness derives not from the dangerous nature of the act but from the rightfulness of someone to engage in it. The wording cannot be extended so as to decide the ultimate legality issue and thus does leave an ambiguity in the Code.

The net effect is that the present *Criminal Code* provisions relating to medical treatment do not alter the basic position at common law on the issue of the burden of proof. Moreover they do not lift the ambiguity concerning the equivocal nature of properly performed medical acts.

2. Other Jurisdictions

British law is similar to that of Canada in that medical treatment falls within the offences against the person because it is an application of force. However, there is a major difference. Britain never did adopt Stephen's suggestion in his Draft Code

for the defence of surgical justification. In order to overcome this situation, the common law on a case by case basis has established criteria for the justification of surgical operations which have been summarized by Dworkin as: (1) full, free and informed consent, (2) therapeutic benefit, (3) lawful justification, and (4) performance by a person with appropriate medical skills.[46]

One American position as indicated by the proposed Federal *Criminal Code* is analogous to the British common law and Canadian *Criminal Code*. Offences involving danger to the person give rise to criminal liability except if certain conditions in the form of defences exist. These conditions include knowledgeable consent,[47] a recognized form of treatment, physical or mental health, emergency, and court order.[48]

French law, too, finds the basis of ultimate legality in a general legislative pronouncement of justification. Consent is not a justification for bodily harm according to the French Penal Code, but the utility of an act, particularly medical acts and sports, may provide justification.[49] A doctor may act without consent in the case of emergency.[50] There are specific legislative provisions for marginal or questionable procedures such as sterilization.

While most criminal legislation ties treatment with the offences against the person and then provides specific defences, the Austrian and German criminal codes are an exception. They make all of the above mentioned elements of the defences elements of offences,[51] thus placing a heavier burden of proof on the prosecution.

The German Draft Penal Code of 1962 goes the furthest to relieve the uncertainty of ultimate legality. Medical treatment does not constitute physical harm if necessary and performed for broadly therapeutic purposes.[52] Unconsented medical treatment is an offence except in emergencies where there has not been an express refusal.[53] The Alternative Draft Penal Code of 1977 specifically legalizes consensual battery and sterilization if certain conditions are satisfied. However, unconsented medical treatment may still fall within some offences against the person with the provision of a necessity justification.[54]

PART III

Treatment and Our Present Criminal Law

1. *Criminal Code* Offences Against the Person

For the criminal law generally, all application of force upon the body of another constitutes an offence against the person. Thus, the administration of treatment falls into that category, as set out in Part VI of the *Criminal Code*. While treatment may also be the subject of other *Criminal Code* offences such as fraud and sexual assault and offences under the *Food and Drugs Act* and the *Narcotic Control Act*, our primary concern here is the potential liability for the administration of treatment within the meaning of Part VI of the *Criminal Code*.

In this section the Commission undertakes a study of the potential scope of liability for treatment through an examination of some of the most obvious offences under which someone may become liable in the normal course of treatment. General rules and possible exceptions applicable to treatment will be analyzed as they appear from the elements of an offence.

Having established the potential scope of criminal responsibility, the Commission will then consider in section 2 the available defences. Discussion of the issues arising in this Part and the considerations and limitations of the *Criminal Code* follows in Part IV.

A. Assault

An assault is the intentional or reckless threat of or application of force upon the body of another without consent.[55] The necessary elements are intention, application of force, and lack of consent.

The "intention" of assault is "exclusively referable to the physical act of applying force to the person of another".[56] The intention refers to the act done to achieve an immediate end, in the absence of accident or honest mistake. In administering treatment, there is no doubt that the requisite intention to apply force exists.[57]

The act of applying force, directly or indirectly, means to bring something into contact with the body, or, to administer something. "Administer" includes leaving something for someone to take, such as medication.[58] Thus, "every medical interference with the body of another is [at first impression] an assault".[59] This has been suggested to include the taking of blood,[60] the examination of urine,[61] and examination by x-ray.[62]

The application of force does not constitute assault if there is a legally effective consent. The consent may be imposed by law or otherwise legally permitted.[63] "Imposed by law" means that either legislation or judicial orders may authorize treatment provided they are made within jurisdiction. For example, a magistrate who made an order for physical examination of a woman without the right to do so was convicted of assault.[64] The effect and limits of consent generate the greatest risk of criminal assault for the administration of treatment.

Authorization by law alone will be sufficient in rare cases despite the wishes of the person. This may be so in the administration of treatment by a duly qualified medical practitioner without consent pursuant to provincial health legislation.[65] The *Criminal Code*, however, is silent on the limit of valid intrusion into the patient's right of refusal. Most of the situations involving nonconsensual administration of treatment by lawful authority have arisen in the provincial context and have not been the subject of comment of criminal law, except in discussion of

the defence of necessity and in textbooks for the initial recognition of the validity of consent by law alone.

Lack of consent by the victim, as a fact, must be shown by the prosecution in all other cases of assault.[66] Despite an apparent consent, the scope of it may be such as to render the conduct nonconsensual.[67] In cases of consensual fighting for instance, the courts on an assault basis have recently looked at the scope of consent, to discover if the actions were "outside the scope of the consent that had been given". In so doing, they have looked to whether the fight was conducted in a "normal manner".[68] Another application of the rule arises in games of sport where consent is implied by willing participation. In these cases the consent is limited in scope by law to those assaults inherent in and reasonably incidental to the normal playing of the game. The test of scope of consent has become a significant factor in Canadian criminal assault law. British common law on the contrary concentrates on factors of bodily harm and public policy. From the finding of these cases and the recognition of the individual's right to limit his consent in private law cases,[69] one may foresee that a consent limiting treatment could expose physicians to liability for assault in the absence of a specific defence.

Not every case of apparent consent by the person is legally recognized as individual consent. The effect of consent depends upon (a) its being freely given, (b) it going to the nature of the act, and (c) its being given with the ability to understand. In private law, this means there must be voluntariness, knowledge, and capacity, respectively. In addition, British common law suggests that there are limits beyond which nobody can consent. They are the inability to consent to bodily harm and to acts which are not within an approved social purpose: These arguably apply in our Code. All of these factors will be discussed in turn.

"*Freely given consent*" means the absence of fraud or duress.[70] Fraud negatives consent if it goes to the nature and quality of the act or identity of the actor.[71] In an early case involving sexual assault on the pretext of medical treatment, the fraud went to the characterization of the act as beneficial in that it

was represented to be necessary and proper for a cure.[72] In civil law, it is necessary that the information given be such as not to mislead a patient about the nature and purpose of the treatment. Duress may similarly negative consent if undue pressure is brought to bear upon the decision-maker so as to impugn the free exercise of his will. This can be implied from a position of authority resulting from a relationship as, for example, schoolmaster and pupil.[73] However, as discussed above, a surgeon or physician is not or should not be in a position of authority in the sense of control as to affect an individual's consent, in the absence of factors external to the relationship.

"*Consent to the nature of the act*" implies a foundation of knowledge.[74] While this has been described in other contexts as "knowledge of the purpose of the operation",[75] "knowledge of the events",[76] and "perception as to what is about to take place, as to the . . . character of what [is done]",[77] it is not at all clear as to how far this goes towards the requirement of reasonable information disclosure for "informed" consent in private cases.

The requirement of "*ability to understand*" can be implied from the facts of Canadian cases.[78] It has been specifically required with regard to minors in England,[79] where it was held that if a child of the age of understanding was unable to appreciate the nature of an act, apparent consent was no consent at all. The aspect of a minor's consent in assault is not addressed in the Code, although specific age provisions for children are made for other purposes.[80] Presumably the same test would be applied to incompetents.

The conditions above pertain to the legal effect of an apparent consent and the circumstances that may vitiate it. But there are some applications of force to which British common law has said nobody can consent and these are particularly significant to medical procedures if applicable in Canadian law.

In *R. v. Donovan*, it was decided that if "bodily harm is the probable consequence [of an assault, then] consent is immaterial"[81] because consent cannot render an unlawful act lawful. "Bodily harm" is any injury which interferes with a victim's health or comfort. It does not need to be permanent but must

be more than transitory.[82] Exceptions to this rule include contests of wrestling in friendship, rough sport or play,[83] and chastisement in the parent-child relationship. The *Donovan* case concerned the caning of a woman to gratify a sexual perversion. Those facts may have influenced the ruling which distinguished the earlier decision of *R. v. Coney*. In this latter case, one of the judges wrote that the injury must be of such a nature as to be "injurious to the public as well as the person injured".[84] This overriding test of public interest was approved by the majority in *Bravery v. Bravery*, a case involving sexual sterilization, where the court said that they "were not prepared to hold in the present case that such operations must be regarded as injurious to the public interest".[85] However, Denning L.J. in the same case stated that the social policy test was one of "just cause and excuse", a test that has been interpreted to be narrower than "injurious to public interest", especially for medical procedures.[86]

The combined tests of bodily harm and public interest have a crucial effect on the legal consequences of the administration of treatment. The meaning of "bodily harm" is apparently broad enough to include most treatments beyond examination and simple diagnostic tests. Even with the overriding public interest tests, it is still debated whether or not consent could ever be given to donor transplantation surgery, cosmetic surgery, transsexual surgery, or sterilization. Even if these procedures could not be consented to under Canadian law, it is unlikely that consent would be ineffective for most medical procedures, because most treatments are for the health of an individual and not intended to cause bodily harm.[87] Medical procedures were not contemplated in *R. v. Donovan*, one of the recognized exceptions, because there was no medical treatment. Furthermore, most medical procedures would not be viewed as injurious to the public. Finally, many controversial treatments have been legislatively approved or facilitated.[88]

The best and most acceptable view is that this law has only historical interest in Canadian criminal law. The preponderance of Canadian commentary excludes the applicability of the "bodily harm public interest" rule.[89] According to section 8 of the Code, all offences are contained in the Code. Since *R. v.*

Donovan, the assault provisions of the Code have been amended without reference to the *Donovan* requirements.[90] The Canadian position is to examine the consent to an application of force in relation to its scope and character according to the criteria that it be freely given, that it go to the nature of the act, and that it be given with the ability to understand.

B. Failure to Perform Duty to Provide Necessaries

Failure to provide necessaries when there is a duty to do so, may constitute an offence in the absence of lawful excuse. The *Criminal Code* establishes the duty of parents and guardians to supply necessaries to children under sixteen,[91] of married persons to supply necessaries to spouses,[92] and of all persons having others under their charge to supply necessaries to those unable to withdraw from their charge because of detention, age, illness, insanity, or other cause and unable to provide themselves with necessaries.[93] Although the duty is the same in each of these three cases, the offence differs as to essential elements.[94] Parents, guardians and married persons commit an offence for failure to perform the duty if the children or spouse are destitute or necessitous, if life is endangered or health permanently injured.[95] All persons having another under their charge commit an offence for failure to perform the duty if life is endangered or health permanently injured.[96] An omission to perform a duty implies, especially when joined with the concept of lawful excuse, the requirement that the person obligated to act was aware that performance was needed.[97] It is not known whether awareness would be implied from professional status but certainly in all other cases, it should be shown to exist subjectively.

The expression "*under his charge*" includes the care and custody of someone who is helpless whether or not such care and custody is imposed by law or voluntarily incurred.[98] Someone may be under another's charge because of a contract or relationship. Hospitals, doctors, nurses and others who contract to care for someone who is helpless because of illness, insanity, or age thus have a duty to provide necessaries.[99] The question of helplessness is one of fact to be decided by a jury.[100]

The application of the concept of "*necessaries*" may vary but includes "medical treatment",[101] "medical care",[102] "medical assistance"[103] and "medical aid".[104] The interchanging terminology and the specific facts of the cases indicate that this term will be interpreted to mean anything necessary for the prevention, cure or alleviation of disease or disorder that threatens life or health.

The absence of lawful excuse is an element of the offence. The inability of the accused to provide[105] or the wilful choice of the person to whom the duty is owed[106] not to receive them constitutes lawful excuses. Conscientious or religious belief, however, has been held not to be a lawful excuse in a series of early judgments.[107] Since then, however, the Supreme Court of Canada has affirmed religious freedom within the context of sedition[108] and Sunday observance,[109] thus leaving open to discussion the limits of religious freedom.[110]

C. Breach of the Duties of Persons Undertaking Acts and Undertaking Acts Dangerous to Life

The *Criminal Code* imposes duties upon those performing dangerous acts and upon those who undertake to perform acts if a failure to perform may be dangerous to life.[111] There is no specific penalty created for these duties. Technically, they fall within the general offence provision of the Code although there is no reported use of this section in this manner.[112] Moreover there have been no cases where breach of these duties alone has been the subject of prosecution. However they have been significant, within the context of criminal negligence, as we will see later.

> Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and use reasonable knowledge, skill and care in so doing.[113]

Because this duty is of primary importance to the appreciation of the criminal law dealing with medical treatment, it needs to be analyzed with care.

The duty to have and to use reasonable knowledge, skill and care applies to "everyone". The Code does not discriminate between licensed and unlicensed persons,[114] thus reflecting a line of common law dating to the early nineteenth century.[115] The narrow import of this attitude is that being unlicensed is not, in itself, an unlawful act within the meaning of "other lawful acts" in the section. This was considered fair because licensure varies from province to province and "the general criminal law is intended to be identical in all the provinces".[116]

This view on licensure needs to be re-evaluated in light of modern developments. It arose prior to enactment of the *Canadian Bill of Rights* and judicial interpretation of equality before the law. The Supreme Court of Canada in 1974 has recognized that equality before the law does not mean that a statute must have application to everyone and in all areas of Canada.[117] Legislators may classify persons according to valid federal objectives and this may, in the present case, include the desire to differentiate the qualified from the unqualified, for purposes of treatment offences in the Code.[118] Also, it is arguable that there has been a return to the ancient principle of strict liability for unlicensed persons by application of the "reasonableness" test as discussed below.[119] Furthermore, the original purposes of non-discrimination were that unlicensed persons existed prior to licensure and that many individuals in remote areas would be without assistance if unlicensed persons were not allowed to practice.[120]

The Code imposes no duty to administer treatment in the sense of requiring affirmative action. However, once one "undertakes" to do so, one must then have and use reasonable knowledge, care and skill. This position reflects an ancient principle of common law which does not force someone to take action to protect another[121] and in the case of treatment mirrors the ethical position that physicians should be allowed to choose freely whom they will serve.[122] Contrary to private law and ethics, however, the Code does not recognize a duty to act in emergency cases, although it encourages administration of treatment in "cases of necessity" by exempting these situations from the duty of reasonable knowledge, care and skill.[123] The requirement of positive action for an undertaking to arise, was made

clear in the St. Germain case. A doctor on duty in the emergency ward of a hospital was found not to have undertaken to treat all who came into the ward, within the meaning of this *Criminal Code* section.[124] The undertaking may arise by contract or by implication through a relationship established by conduct of the parties and surrounding circumstances. Thus, a doctor "undertakes" to treat once the physician-patient relationship is established;[125] a hospital "undertakes" to treat when it admits a patient into the facility;[126] a nurse "undertakes" to administer treatment when responsibility for a given patient is accepted within the scope of employment. Also, once one undertakes to treat, it may be that the responsibility cannot be shifted through delegation.[127]

The "administration" of treatment means the methodology used in the application of the treatment to the person. It includes the giving of a drug, the use of machinery and external techniques to monitor the progress of therapy and the positioning and placement of a person so as to receive treatment properly. In short, "administration" covers the process of activity purposefully aimed at the giving of a treatment to a person. As such, more than one person may be involved in the administration.[128]

The duty is imposed upon any person who undertakes to do a lawful act which may endanger life.[129] The idea of danger implies liability or exposure to death in its simplest meaning. The notion here is limited to death and does not include interference with health. The danger must also be evaluated as serious enough to threaten life.

Those three conditions (the existence of an undertaking, the act of administration, and the characterization of the act as endangering life), are precedent to the establishment of the legal duty to have and to use reasonable knowledge, skill and care. The "having" and "using" directly relate to the norm of "reasonable".

What is "reasonable knowledge, skill and care" depends on the facts of each case. Reasonableness has been determined on the evidence of qualified or licensed personnel.[130] A rule has

evolved to the effect that the "reasonable knowledge, skill and care" which one must have and use, is that possessed by knowledgeable persons qualified by proper training.[131] The test is an objective one. It is designed to evaluate whether the accused acted "with the competence the law requires", which is the average competence of a licensed person trained to do the same act.[132] This "average" level has been the focus of considerable debate. It implies in a way that half of the practitioners could never reach the competence the law requires. A better view is to recognize a minimum standard of competence as is acceptable by professional standards. Either way, the level of competence now required represents an increase from the earlier level of the "least qualified doctor".[133]

An assumption of unreasonableness might also be made if ordinary common sense suggests that the application of standard medical procedures to the case involved obvious and unnecessary risk.[134] This places a heavier burden on an unlicensed person. Reasonableness ". . . will in practice doubtless be more easily proved in the case of the licensed practitioner than in the case of the unlicensed practitioner". It was thought however that the total effect would be to maintain the non-discretionary stance away from strict liability for the unlicensed.[135] Nevertheless, recent judicial pronouncements indicate acceptance of the earlier common law attitude[136] favouring strict liability for one who administers treatment unknowingly when common experience should warn him of danger.[137] Recent cases do not make a distinction between an ignorant person administering treatment honestly, and a person holding himself out as a member of a licensed profession and administering treatment.[138] Furthermore, because of the prejudicial effect on juries, civil courts are reluctant to admit lack of a licence in evidence, but the position is unclear in criminal law.[139]

The "reasonableness" approach also fails to consider the higher degree of skill expected at least in private law of medical specialists[140] and the effect of an average requirement in the area of medical experimentation. By focusing on the average competent medical person, the standard may not represent societal expectations of the specialist nor recognize that certain experi-

mental interventions would never be within the knowledge of the average doctor.

In addition to the two duties of provision of medical treatment and of reasonable knowledge, care and skill, the *Criminal Code* imposes a duty upon those who have undertaken to do an act, to complete it if an omission is or may be dangerous to life.[141] This duty existed in common law and was included in the first *Criminal Code* of 1892.[142] The criminal law has always been reluctant to hold someone criminally responsible for harm which can be traced to his inactivity and does so only if one has a duty to act or undertakes to act.[143] In relation to treatment, the duty here is broader in scope than that of section 198 and may include the complete notion of medical abandonment if it endangers life.

The "undertaking" requires an affirmative action such as entering into a doctor-patient relationship or taking someone under one's care. However, the undertaking is not limited in scope by words such as "to administer". The duty can thus be read to apply to the total scope of the undertaking. One of the implied terms of the doctor-patient relationship or contract is that the doctor must provide continued needed care and cannot unilaterally withdraw without giving the patient reasonable notice so as to enable him to secure an acceptable substitute.[144] The undertaking may be otherwise terminated upon mutual consent, revocation by the patient, or lack of need for medical services.[145] Although undecided in law, academic opinion is to the effect that the refusal of treatment by a patient does not necessarily constitute revocation of the doctor-patient contract and does not justify abandonment by the doctor.[146]

The expression "an omission to do an act" in section 199 invokes the idea that the person to act is aware that performance is required or needful.[147] Within the confines of medical treatment, such an omission is characterized as abandonment. Once the undertaking to treat is established, there must not be an unjustified withdrawal from a case such as, for example, the complete and unreasonable refusal to treat, the withdrawal at a crucial juncture without the patient's consent or reasonable notice to him, or the premature discharge of the patient.[148] Most abandonment cases in private law involve negligence. With-

drawal is an intentional act and is usually motivated by a malpractice component.[149] The only assistance as to possible criminal law response in this area is that a refusal on religious grounds to perform a necessary operation might result in a charge of manslaughter by negligence if death is a result.[150] This legal position is consistent with the ethical obligation imposed upon Canadian doctors to render therapy in an emergency or when the patient is unable to consent, even though the same doctor may, in non-necessitous situations, refuse to perform certain procedures because of conscientious objection.[151] Here one would tend to limit the meaning of "emergency" to situations in which the very life or physical integrity of the patient are at stake.

Finally, the omission must possibly be dangerous to life, thus requiring a causal connection between the omission and the danger. There are no cases on this duty relative to treatment.

D. Causing Bodily Harm with Intent

The offence of causing bodily harm with intent is of particular significance to treatment. Everyone who, intending to wound, maim or disfigure, causes bodily harm is guilty of an offence.[152] The usual legal meaning given the words "wound", "maim" and "disfigure" are broad enough to cover certain medical procedures. "To wound" is to break the skin, inclusive of surgery.[153] "To maim" is to injure a person so he is less able to fight or defend himself,[154] and is clearly inclusive of surgical amputation and some psychiatric treatments. "To disfigure" is to do some external injury which may detract from physical appearance, inclusive of cosmetic surgery.[155] As indicated above, the definition of bodily harm embraces any interference with health or comfort that is more than transitory. In performing surgery, someone clearly intends to "wound" as that is an essential element in surgical procedures. Similarly, in amputating a limb, it is within contemplation that the impairment will lessen the amputee's ability to defend himself. Finally, all cosmetic surgery affects an intentional alteration in physical appearance and it is a question of appreciation as to whether it constitutes an improvement or a disfigurement.

E. Criminal Negligence

Criminal negligence arises when, through wanton or reckless disregard for the life or safety of another, death or bodily harm is caused.[156] The law of criminal negligence deriving from this basic rule is exceedingly complex and susceptible to varying interpretations. However, a framework for analysis for purposes of treatment can be constructed.

The essential elements of the offence of criminal negligence are as follows: (1) a duty or undertaking to act, (2) an act, or omission to act characterized as negligent, (3) wanton or reckless disregard for life or safety, and (4) death or bodily harm caused by such negligence.[157]

(i) *Duty or undertaking to act*

The obligation to perform an act can only arise within criminal negligence where there is a "duty imposed by law".[158] "Law" has been interpreted to mean all legislative enactments, both federal and provincial.[159] Thus, duties relating to treatment may arise under the *Criminal Code*, under federal legislation or under provincial legislation, inclusive of regulations.

- Under the Criminal Code

The three duties arising with respect to treatment in the Code have been outlined above.[160] All may form the basis of criminal negligence if a failure to perform the duty causes death or bodily harm and if the requisite intent exists.

- Under Other Federal Legislation

In addition other federal legislation imposes duties, an omission or breach of which could give rise to a charge of criminal negligence.[161] Particularly pertinent to treatment is legislation such as the *Food and Drugs Act*,[162] the *Narcotic Control Act*,[163] and the *Penitentiary Act*.[164] It is beyond the scope of this paper to discuss the relevant duties arising from these Acts in detail. Two examples will suffice to illustrate the possibility of criminal negligence arising from an omission with respect to those duties.

Under the Narcotic Control Regulations, a medical practitioner must not administer, prescribe, give, sell or furnish a narcotic to anyone who is not under his professional treatment and who does not require the narcotic for the condition for which he is receiving treatment.[165] The giving of a narcotic under other circumstances constitutes a breach of this obligation and if the narcotic causes death or bodily harm and if the doctor has the requisite mental state, criminal negligence could conceivably be adjudged.

The Penitentiary Regulations provide that every inmate shall be provided, in accordance with directives, with the essential medical and dental care which he requires.[166] It has been suggested that failure to provide an inmate with essential medical care in accordance with directives, could well provide a basis for criminal negligence.[167]

- Under Provincial Legislation

Failure to perform a duty required by provincial law may give rise to criminal negligence within the meaning of the *Criminal Code*.[168] This includes all legislative enactments, including regulations passed by hospitals and the College of Physicians which are approved by Order-in-Council. In this way, a doctor in Québec, because of section 2 of the Charter of Human Rights and Freedoms, is obligated to render aid and the best care possible to a patient in immediate danger.[169] Provincial legislation affecting hospitals, public health, mental health, workmen's compensation and the health disciplines also contain variable duties requiring affirmative action. Reference should thus be made to them to determine the exact scope of duties arising within the meaning of "duty" in criminal negligence.

(ii) *An act or omission to act characterized as negligent*

The act giving rise to a charge of criminal negligence is the causation of bodily harm or death by the conduct of the accused in circumstances described as negligent. It is no longer necessary to refer to the degree of negligence required to render the act in question criminal; a breach of duty plus recklessness is sufficient.[170] Thus, failure of parents or persons in charge to provide medical treatment,[171] failure of doctors to provide necessary treatment in an emergency in Québec[172] or failure of

health personnel to provide medical attendance once having undertaken to do so[173] will constitute criminal negligence if it shows wanton or reckless disregard for life or safety and the causal element is established.

(iii) *Wanton or reckless disregard for life or safety*

Canadian case law has tended to confuse the two elements of "act" and "recklessness" with a resultant application of an objective test of the accused's mental state based on his conduct.[174] As stated most recently by the Supreme Court of Canada, the breach of an obligation imposed by law, in most cases, is evidence of the intent.[175] "Conduct disclosing wanton or reckless disregard for the lives or safety of others constitutes *prima facie* evidence of criminal negligence . . . and deliberation is not . . . a necessary ingredient of the offence."[176] Thus, the subjective aspect of recklessness requiring the accused to have adverted to the consequences of his acts does not appear to be an element in criminal negligence. Although rejecting subjective foresight, the Supreme Court does not appear to reject the requirement of a mental element in the sense of making the offence a crime of strict liability.[177] However, the mental element required is unclear and cannot otherwise be discerned from the cases. This situation is and has been the subject of intense academic comment which is beyond the scope of this paper.[178] For present purposes, it should only be noted that the movement is towards an objective notion of recklessness which is imputed from conduct.

While an objective mental element is problematical for criminal negligence in general, this has been the accepted test for medical treatment within the "reasonable knowledge, care and skill" requirement. The case of *R. v. Rogers* has made this clear as follows:

> I want to make it clear to you that the standard of professional skill, knowledge and care required of a physician and the standard of knowledge, skill and care required of any person whatever his qualifications, who undertakes to administer medical treatment, is an objective standard. In other words, in a particular case it is entirely irrelevant, it does not matter at all, what the particular practitioner or person thinks is the level of skill, knowledge and care with which he gave treatment. The only test is whether in fact and regardless of what he may think about

> it, he did act with the competence the law requires of him. Failure to act with that degree of competence is negligence. . . . whether you have been negligent or not, and whether your negligence is so great that it amounts to criminal negligence, in other words wanton or reckless disregard for the lives or safety of other persons, isn't tested by what the person who is accused thinks about it. I would say for obvious reasons, it is tested objectively by the standards of reasonable people.[179]

Not only does this case confuse the act of negligence with the mental requirement by reference to degrees of negligence as the meaning of "reckless", but the effect of this test comes dangerously close to creating an offence of strict liability for unlicensed persons in most cases.

The situation is not so clear, however, for cases arising outside the "reasonableness" duty. In the Québec emergency treatment case, the court considered the subjective evaluation of the accused. However, it then rejected his conclusions in the face of evidence as to the acceptable conduct in similar circumstances and the specific situation on the day in question.[180] This test approaches Williams' "double-barelled" test of recklessness which considers the subjective foresight but then subjects it to an overriding objective inquiry into the magnitude of the risk, the acceptability of excuses offered, and the measures which would have been necessary to obviate the danger.[181]

The uncertainty promoted by a long line of Canadian case law in this area is problematical for the practising doctor. The lack of clear guidance by the courts leaves open the scope of public review of professional judgment. In overlooking the subjective state of mind of the doctor, one disregards the unavoidable stress, difficulty, and dubiety of many medical situations which leave a doctor little time to assess the reasonableness of a course of action.[182] At the same time, it is desirable to look beyond the subjective state of mind to the overall reasonableness of a decision since questions as to the duration or quality of life are not for the doctor alone to decide.[183] These considerations are of paramount importance within the context of the termination of life-prolonging or life-saving treatment.

(iv) *Death or bodily harm caused by such criminal negligence*

For criminal negligence to exist, a person must have caused either death or bodily harm.[184] Although bodily harm is defined in case law, there is no definition of death for the *Criminal Code*. This raises problems peculiar to this age of medical technology when life supports procedures can maintain vital life signs for prolonged periods of time. There are cases where someone has caused that which would otherwise be death, (according to the usual criteria of cessation of cardiac and respiratory function), but because of artificial support, something that does not meet the traditional concept of death from which there is no hope of recovery, a condition referred to as "brain death". An additional problem arises when a medical decision is made in such cases to withdraw life support procedures.[185] These matters, in the opinion of the Commission, require legislative response and are the topic of a separate Working Paper.[186]

The traditional theory of causation in criminal law is that, while there may be several causes of one event, each one factor may be regarded as a cause, provided that the event would not have taken place had that factor not existed.[187] Although modern theory relies on the mental element requirement to alleviate the effect of this causation rule, it exists to determine, as a question of fact, whether the accused's conduct caused the harm.[188] A second part of the question is whether there are any legal principles which preclude factual causation for legal purposes.[189] As a matter of law, the homicide provisions of the *Criminal Code* contain sections relating to intervening causes,[190] acceleration of death,[191] and time interval between the act and death.[192] These provisions, however, have been held not to apply to criminal negligence causing death,[193] thus leaving the legal framework of causation in criminal negligence in an uncertain state and totally dependant upon directions from common law principles.

In the case of criminal negligence for failure to administer treatment, the causal question to be proven is whether the conduct caused bodily harm or death or whether the conduct hastened death. In most cases involving an omission by medical doctors, the patient was already in a moribund state when he

came to the attention of the accused and death was ascertained to have been caused by that state.[194] Moreover, causation was unproved because it was doubtful that the action that could have been required would have saved life.[195] This raises a question as to the degree of likelihood required. Any serious doubt as to the efficacy of the recommended procedure is to be resolved in favour of the accused.[196] Naturally, it is impossible to prove that recommended treatment would have cured the patient; if the conduct significantly decreased the life span, the law will not countenance an accused saying someone would have died in any event.[197] If medical evidence establishes with reasonable certainty or probability that the conduct shortened life, then causation is established.[198] It is not sufficient that treatment might have saved life.

Additional considerations pertaining to the victim's own conduct may arise. Although these considerations are based on common law cases dealing with homicide, it is likely that the same principles would apply to criminal negligence and causing bodily harm.[199] The first difficulty is failure of the patient to care properly for himself, a situation which courts have been reluctant to consider as negativing the causal connection.[200] The second difficulty is the refusal to undergo ameliorating treatment, a situation which likewise does not negative the causal connection.[201] Both of these situations arise also within the private law context where, although there are opinions to the contrary, the right to refuse treatment is generally recognized.[202]

Because criminal negligence is a means of committing culpable homicide in the *Criminal Code*,[203] much of the above discussion is relevant to the ensuing analysis of the homicide provisions of the Code as they may affect the administration of treatment.

F. Homicide

Homicide is the killing of a human being. Although the law treats all homicide as a matter of utmost gravity, not all homicides are regarded in law as unlawful, criminal or culpable.

Those homicides which are culpable are distinguished by their nature into the crimes of murder, manslaughter, and infanticide.

A person commits culpable or blameworthy homicide when he causes the death of a human being by means of an unlawful act[204] or by criminal negligence.[205] Although "unlawful act" means any act contrary to law, the act must be such that "any reasonable person would inevitably realize must subject another to the risk of, at least, some harm, albeit not serious harm".[206] An assault may constitute such an unlawful act[207] as might a breach of provincial law if harm were reasonably foreseeable. Similarly, an act which is unlawful because it is a tort may constitute manslaughter, if death is accidentally caused and the tortious act is likely to cause bodily harm. However, a negligent act must be criminally negligent to be manslaughter. Thus on the basis of assault and the other offences already mentioned, the actions of a person administering treatment may be brought within homicide. To commit murder is to cause death by an unlawful act or criminal negligence with either an intention to kill[208] or an intention to cause bodily harm which will likely cause death with recklessness as to whether death in fact occurs.[209] The test for recklessness is still in the uncertain state as mentioned in criminal negligence above. However, it is clear that within intentional murder, a subjective test of foreseeability is required.[210] On this subjective basis, what the reasonable person ought to have anticipated is merely evidence from which the conclusion may be drawn that the accused anticipated the same consequences.[211] To commit murder, the accused must know his act is likely to cause death.

Thus, it is not murder where someone administers treatment with due care to prevent harm which he, as a reasonable person would foresee might arise, and death accidentally or unexpectedly occurs.[212] However, there are situations where the requisite specific intent may exist and which raise serious questions.

A first example is the cessation of life-saving treatment or the decision not to administer treatment within the euthanasia context. The criminal law does not recognize motive, however noble, as affecting liability.[213] Because cessation of treatment is

the topic of a further Working Paper, it will not be discussed here.

A second situation involves the very rare case of intentional killing through treatment for reasons outside euthanasia. Although there are no known cases of this nature in Canada, the United States has considered two murder cases of this type. The first involved the murder conviction of a chiropractor who assured parents that he could cure a young girl's cancer without surgery. As a result of these assurances, the girl was removed from hospital and her life shortened. On appeal, the verdict was overturned because of a misdirection that the false representation to the parents constituted a felony so as to bring the accused within the felony murder rule which is satisfied with objective intent. Because the chiropractor unreasonably but sincerely believed that his actions were in the girl's best interests, a manslaughter instruction should have been given.[214] In another case, a medical doctor was acquitted of murdering five New Jersey hospital patients in a bizarre scenario involving accusations of illicit conduct among physicians.[215]

Situations involving murder within the treatment context are extremely rare and most culpable homicides for treatment fall within manslaughter. Culpable homicide which is not murder or infanticide is manslaughter.[216] If the state-of-mind requirement for murder is absent and the accused's conduct caused death, manslaughter must be considered.[217]

There are several cases of manslaughter by criminal negligence in the administration of treatment, although few are of recent origin.[218] The same principles of criminal negligence apply as above and, in fact, it is exceedingly difficult to ascertain the difference between criminal negligence causing death, and manslaughter, especially in view of uncertainties regarding the nature of the mental element. Certainly, good intentions and expectations of beneficial result do not decide the issue, if criminal negligence is found. Manslaughter may also arise by unlawful act in the administration of treatment but has not arisen in Canada.

A scenario to be considered within the homicide provisions is the denial or withdrawal of life-saving therapy because of scarce medical resources. How does the present legal structure reflect the situation where a patient in need of dialysis is denied access because of scarcity of supply, or where an elderly patient is withdrawn from dialysis to facilitate the treatment of a young person? Both acts are done intentionally and with the knowledge that as a direct result of the denial, the patient will die.[219] The question relates to the scope of the undertaking within the doctor-patient relationship already discussed above. It is argued that the undertaking is to supply the minimal level of treatment and that this level is nothing more than what can be done for all patients.[220] It is further suggested that the duty is to provide "ordinary" care and that if resources be unavailable, it can be said to be "extraordinary", and therefore beyond the scope of the duty.[221] However interpreted, the law is unclear and uncertain. Ultimately, the situation calls for justification by necessity or specific recognition of the special circumstances surrounding the termination of treatment.

The allocation of scarce life-saving resources is the final example of potential criminal liability for treatment within the *Criminal Code* offences against the person. The apparent broad scope of liability is due to the non-discriminatory attitude of the Code in protecting all interferences with the person which fall within the description of the offences. Although the lack of any one of the constituent element of an offence renders an act non-criminal and in this sense is a very significant aspect of defence, there are specific defences available which further bring treatment outside the scope of criminal liability. Thus, a real evaluation of the scope of liability must await the delineation of available defences.

2. Available Defences

The specific defences available in the *Criminal Code* and the common law serve to make theory conform to reality.[222] The potential liability for offences in the administration of treatment

creates an apparent conflict between the *Criminal Code* and the popular sentiment towards medical treatment, a conflict which is partially resolved through the availability of certain defences.

The purpose of a defence is to raise the absence of either criminal conduct or criminal harm, and to refute or cast doubt upon the criminality of a specific act.[223] The characterization of an act as a crime will take into account the defence concepts of justification and excuse. These concepts serve to direct analysis of a case to either the external situation or mental element, but otherwise do not convey substantive meaning.[224] Thus, defences by justification pertain to external situations which render an act privileged; defences by excuse pertain to the person or character of the accused.[225]

The defences made available in the *Criminal Code* for the administration of treatment specifically relate to the external circumstances which render the application of force privileged. Other defences related to the person of the accused may also apply, but only the most pertinent ones will be discussed. It should be noted that consent is often considered a defence. This problem has already been discussed in the context of assault and will not be mentioned again here.

A. Justification for Surgical Procedures

Under section 45 of the *Criminal Code* everyone is protected from criminal responsibility for performing a surgical operation upon any person for his benefit, provided that the operation is performed with reasonable knowledge, care and skill and that it is reasonable to perform the operation having regard to the state of health of the person at the time of the operation and to all the circumstances of the case.[226] Section 45 is found in the "General" part of the *Criminal Code*, thus "indicating its applicability, according to the circumstances, to all provisions of the *Criminal Code*", with the exception of abortion.[227] Subject to that notable exception, it applies to everyone, regardless of where the operation is performed.[228] With one minor exception,[229] this section has remained unchanged since its appear-

ance in the first Code of 1892, and its formulation by Stephen in 1877.[230]

Recent judicial discussion suggests that the defence of surgical operation is distinct from, and narrower than, the common law defence of necessity. In *Morgentaler v. R.*, Chief Justice Laskin noted that section 45 of the Code is limited to surgical operations and does not cover other forms of therapy.[231] Furthermore, the defence is based on objective facts, ascertainable according to reasonableness rather than a subjective aspect.[232] Thus, the central issue in the defence is a context of reasonableness.

There is a divergence of opinion as to whether the defence is confined to the necessity or emergency situation, or whether it extends beyond this situation to surgery which is merely desirable because it is optional. The polemic originates in the notable absence of the element of consent. Three theories have been advanced to rationalize the absence of consent and to delineate the scope of the section.

The first rationale, recognized in Canadian law, is that section 45 may provide the defence to a charge arising out of surgical procedures, where a patient is unconscious or unable to consent.[233] This position is consistent with the historical position adopted by Stephen which differentiated situations where consent is required or not on the basis of incapacity.[234] It is the recognized exception to the requirement of consent in English criminal law.[235] Finally, this rule parallels private law wherein surgery may proceed without consent if the operation is "necessary", as involving "urgency" and "immediate decision" and not merely convenience or desirability.[236]

The second, moderating view, is that consent is not altogether deleted from the section, because the notion of conferring a benefit is its recognized alternative.[237] This theory presents benefit and consent in an "either-or" position and is a form of constructive consent. According to this second view, the provision of benefit in a no-consent situation is a social technique to cause someone to act morally in a situation where he feels he ought to, but which might otherwise seem unfair to the person

acted upon.[238] A philosophical comment on this second approach says that allowing physicians to do what they think is in the best interests of their patients is "crassly consequentialistic at times, excessively individualistic and inherently paternalistic".[239]

A third theory, the widest approach and subject to the same criticism, states that the defence extends beyond the necessity situation to cases where surgery is simply desirable.[240] This view is based on the reasoning that section 45 must have been intended to extend beyond the common law and that the overriding requirement of reasonableness maintains the public policy aspect.

These three competing views suggest at a minimum deficiencies within the section as to the place of consent. They further express the need for enunciation of the criminal law position with respect to human experimentation and the requirement of action in emergencies. Finally, frustration is exhibited with the narrowness of the justification. The section does not deal with an express refusal of treatment. The effective limits of refusal and justification of interference are unstated.

The essential ingredients of the defence are threefold: the surgery must be beneficial, performed with reasonable knowledge, care and skill, and reasonable in the circumstances.

"*Benefit*" is bare and bold, lacking either legislative or judicial description. This first requirement is that the operation be performed "*for* the benefit of [a] person," thus suggesting a beneficial purpose, but not necessarily a beneficial result. The requirement of "benefit" on which to base justification specifically offsets the prerequisite of harm for a crime. Given the meaning of harm as extending to discomfort, there is some overlap between the two concepts since most surgical operations necessarily involve some discomfort which is more than transitory. Also, even the most refined medical techniques carry the possibility of substantial harm.[241] The usual meaning of "benefit" implies that the risk assumed is not disproportionate to the "benefit" anticipated.[242] Accordingly, greater risks may be taken if the alternative be continuing substantial detriment. A

reasonable balance must however always be kept. Radical therapies for instance should not be undertaken if less dangerous but equally good therapies are available.[243]

The Code does not say "medical benefit", thus leaving the kind of benefit open to judicial interpretation. In certain cases of donor transplant private law has recognized psychological benefit[244] and the concept arguably extends in ethics to the principle of totality or whole good of the person.[245] Non-therapeutic interventions arguably fall outside the protected beneficial sphere, and includes experimentation, unnecessary surgery, and non-meritorious procedures.[246]

Second, the aspect of *reasonable knowledge, care and skill* in the performance of the operation is the same as discussed above in relation to the undertaking of acts dangerous to life, and needs no further elaboration here.

Third, it must be *reasonable* to perform the operation, having regard to the patient's health at the time, and all the circumstances of the case. This objective test refers to the reasonable balance of risk and benefit and the character of the emergency. These requirements certainly afford no protection to the surgeon in cases of unnecessary surgery. While the categorization of unnecessary procedures is moot, the methodology of determination pertains to the likelihood of benefit to the patient and the variable statistical frequency of the procedure.[247] It may also be unreasonable to perform an operation in the face of an express refusal of treatment by a patient.

Absent from the defence, yet an element of the same defence in other jurisdictions,[248] is the fourth requirement, that of good faith. Good faith is the genuine belief of the person performing the operation in the expected consequences of intervention. It is a subjective evaluation, proved often by evidence of consultation with another doctor.[249] This second consultation has been demonstrated to reduce the incidence of unnecessary surgery.[250] Although it has been argued that this subjective aspect applies to section 45 but does not conclude the issue,[251] the preferred view has been to maintain the distinction between this

objective justification and the basically subjective common law defence of necessity.[252]

B. Necessity

The fundamental question concerning necessity is whether it exists as a defence. Although there are views to the contrary,[253] the broadly accepted position is that the defence of necessity exists in Canadian,[254] and has been recognized in English,[255] and American[256] law. It was indicated by the majority in *Morgentaler v. R.* that if there is a defence of necessity at all in Canadian law, "it can go no further than to justify non compliance in urgent situations of clear and imminent peril when compliance with the law is demonstrably impossible".[257] Such peril includes danger to life.[258]

There are three essential elements of that defence: first, the act must have been done to avoid a significant and greater evil than the offence committed to avert it; second, there must have been no alternative course of action short of the commission of the offence; third, the harm caused must not be more than necessary to avert the evil.[259] Although the accused must have believed that the situation was so urgent as to indicate one course of action, the question of values is an objective one.[260] Thus, whether there was in fact such an urgent situation and whether the harm caused was lesser than the potential harm averted is not decided by the views of the accused, but by a jury. In a normative sense, the defence indicates meritorious behaviour justifying invasion of a right.

The utility of this defence in the administration of treatment in Canada is theoretically unquestionable. At common law and in present English law, the defence of necessity exculpates from criminal liability a surgeon who performs surgery upon an unconscious patient.[261] Presumably, it would have the same effect in Canadian law on the administration of other treatments in similar situations. Thus, the transfusion of a child in order to save life, contrary to parental wishes may be justifiable. In a British case, the medical use of narcotics to kill pain, even though hastening the death of the patient, was not a crime

because of the value of saving the patient from pain.[262] It is beyond the scope of this paper to consider the effect of a general defence of necessity on euthanasia, but the defence may have considerable influence in other homicide situations.

The intentional death of one person in order to save another as in the allocation of scarce resources situation, is an important case in point. Old common law British and American cases are split on the applicability of the necessity doctrine in the classic shipwreck cases. The British case of *R. v. Dudley and Stephens* rejected the evaluation of one person's life over another to justify the killing of an innocent young boy in order to save two seamen.[263] Here, in effect, might was not right in that the end did not justify murderous means. In the absence of a self-sacrificing hero, all must die given that all lives are to be treated equally. In the earlier American case of *U.S. v. Homes*, the throwing overboard of passengers in a lifeboat in order to save some became a situation of necessity once all the ordinary means of self-preservation has been exhausted and the peril was overwhelming.[264] Arbitrary selection, however, was not countenanced; a fair selection was by lot, with the exclusion of the crew from the lottery.[265] Although the decision to select someone for treatment over another is not made by those doomed, these cases provide the only analogy to the allocation of scarce life-saving resources situation. While academic writers disagree on the effect of *Dudley and Stephens*[266] and in the absence of subsequent cases, the law is uncertain as to whether the scarce resource situation constitutes a necessity and as to the method of selecting the victim. If *R. v. Dudley and Stephens* closes the defence whenever comparative lives are selected, necessity is left to the situation where more lives can be saved. *U.S. v. Holmes* recognized necessity based on the exclusion, depending on specified criteria, of certain members of society from a lottery scheme, thus implicitly sanctioning the use of social worth criteria when deciding who shall live and who shall die.[267] Both cases are inadequate and ill-conceived to solve the modern allocation problem. Legislated solutions such as the *Criminal Code*'s specific exception to the normal murder rule whereby in an emergency situation at birth, the life of the mother is to be preserved over that of the child, suggest a possible approach.[268] Although the allocation problem leading to a denial of life-saving

therapy is rare, it will continue and needs realistic legal response.

Another situation involving the saving of a life, but without potential death for all, which may invoke the necessity defence is the forced contribution of rare organisms to save a life. Can the defence exonerate the forced withdrawal of a rare blood type in order to save a life? Although some opinions value the lack of a duty to rescue,[269] others find it incredible that someone may be excused liability for coerced killing while compulsory blood transfusion is not countenanced.[270] This illustrates the inherent value contradictions in the necessity defence.

A provocative application of the defence of necessity concerns the forced feeding of a prisoner on a hunger strike.[271] This British case of 1909 raises serious problems for the institutionalized because if the person had not been in prison, there would have been no justification for interfering against her will.[272] The case, even if considered the exercise of public authority, undermines the right of refusal of prisoners and other institutionalized persons.[273] Although there is no similar case in Canada, it has been argued that consent may not be necessary where treatment is in the interest of the inmate patient.[274] This position, however, is based on an assumption of implied consent which is contradictory to the necessity defence, and arguably inapplicable to criminal law.[275]

These last examples exemplify the problems surfacing when values compete, a difficulty which has so impressed some authors that they have denied necessity as a defence per se but recognized the plea in techniques associated with the elements of an offence.[276] Others who favour the defence value its utility as the general provision for unforeseen cases in the absence of legislative provision in specific cases.[277]

A specific solution for medical treatment has arisen in the United States. In *U.S. v. Randall*, "medical necessity" has been recognized as a specific defence with the values of preservation of life and health outweighing all other social order values.[278] Once a medical condition of necessity exists, all action to save life or health is justified. In *Randall*, an individual possessed

marijuana for self-treatment of glaucoma, a therapy later proven to be beneficial. The case has broad implications in, for example, the use of controlled or banned drugs contrary to regulation.[279] Some such drugs are not proved unsafe or ineffective but simply untested and their benefit to health arguably could be justified under the doctrine of medical necessity. This reasoning could possibly also support the concept of necessity as a defence for euthanasia where no prospect for improved health exists and the choice of death as a lesser evil is a matter of medical judgment, thus wholly confining the defence in such cases to a medically acknowledged condition.[280] In the present state of the Canadian criminal law, it must be noted however that alleged necessity for euthanasia could probably not serve as a defence against homicide.

These alternatives suggest the need for societal guidelines on the value questions raised in the treatment situations and for determination of the best procedural means to effect those values.

C. Mistake of Fact

A mistake of fact affords a defence to an accused provided that he honestly believed in a state of facts which, if true, would have rendered the act an innocent one.[281] This means that the accused thus lacks the requisite intent for a crime. While it used to be required that the belief be both honest and reasonable, there has been a modification away from the reasonableness requirement, except for offences of strict liability.[282] This defence is of obvious utility to cover non-negligent mistakes in the treatment environment. Moreover, the modern interpretation may ease criminal problems associated with certain religious beliefs.

Thus an honest belief that a situation is something other than it in fact is, provides a defence in the bizarre situation when the wrong patient is delivered to the surgeon's table and a procedure is performed different from one for which consent was obtained.[283] While the establishing of such a mistake might well effect the avoidance of criminal liability it could hardly serve to

avoid civil liability. Similarly, the administration of the wrong drug by mistake does not render an accused criminally responsible if there is an honest belief that the correct drug was being administered.[284] In such cases, the honesty of the belief may be evidenced by due inquiry and reasonableness. In administering drugs, it has been held reasonable for a doctor to assume that a nurse will follow instructions and provide the drug as asked.[285]

Under the old rule of reasonableness, a breach of law arising because of unusual or unaccepted religious belief was an unreasonable mistake and therefore not excusable.[286] This was in contrast to the earlier common law to the effect that a conscientiously held belief was a defence, except where a statute imposed a specific duty.[287] The discarding of the reasonableness requirement may open up a defence based on a religious belief, which would preclude medical treatment. However, commentators have suggested that "strange" or "fantastic" beliefs should be approached as a defence of insanity, or characterized as divine commands transcending human law so to be regarded as mistakes of law which do not constitute a defence.[288] Religious belief might be regarded as indicative of motive and not intent and, therefore, not relevant under the mistake of fact defence. Regardless of these divergent views, development of the mistake of fact defence indicates that religious belief could soon be considered anew.

D. Superior Orders

It is generally accepted that it is no defence to say that an act was done in obedience to superior orders. However, it may go to establish a lack of criminal intent, to indicate reasonableness in negligence or to indicate reasonable belief in the lawfulness of the orders.[289] Clearly, there is no crime of acting in obedience to validly enacted laws, such as provincial public health statutes. But problems may arise when acting on hospital directives not approved by Order-in-Council or on court orders made without jurisdiction. A situation in which this defence could possibly be involved is that of the allocation of scarce life-saving resources without the necessary procedural requirements of due process of law.

3. Summary

In criminal law, treatment is characterized as an application of force upon the body of another. All such applications carry potential criminal liability within the Offences Against the Person in Part VI of the *Criminal Code*.

A. Offences

(i) Treatment performed without a legally effective consent constitutes an *assault*. Authorization to perform treatment may be given by law as in cases under provincial public or mental health legislation; however, all other cases require the personal, individual consent of the patient. This personal, individual consent may be limited in scope as the patient wishes. It must be given freely and with knowledge of the nature of the act. It must be given by a patient who is able to understand the nature of the act.

(ii) The *failure to provide the necessaries of life* to someone under one's charge is an offence if life is endangered or health permanently injured. Those who contract to care for helpless persons must ensure that they receive all necessary medical treatment, care and aid. Helplessness may arise through detention, age, illness, insanity or other cause.

(iii) Everyone who *undertakes to administer treatment* must have and use reasonable knowledge, skill and care. This applies both to licensed and unlicensed persons. Reasonableness has been determined according to the professional standard of the licensed person trained to do the same act. In addition, once one undertakes to do an act, there is an obligation to carry it out if failure to do so may be dangerous to life. This means that there cannot be an unjustified withdrawal from a case and as for example, the complete and unreasonable refusal to treat, the withdrawal at a crucial juncture without the patient's consent or reasonable notice to him, or a premature discharge of the patient.

(iv) The offence of *causing bodily harm with intent* is broad. It includes many forms of treatment regardless of consent

or reasonable knowledge, care and skill. This is because "bodily harm" has been defined as any interference with health or comfort which is more than transitory. Further, the required intent is to wound, maim, or disfigure which, in their common meaning, includes ordinary surgery, some psychiatric treatments, and cosmetic surgery.

(v) The reckless failure to perform a legal duty with a resultant death or bodily injury may give rise to a charge of *criminal negligence*. Legal duties include those in the *Criminal Code* but also those arising under federal or provincial law. Although the law on this offence is complicated, one recent medical case illustrates the significance of this offence to treatment. A doctor on duty in the emergency ward of a metropolitan hospital failed to treat a patient who was brought to the ward, but sent him in an ambulance to another hospital. The patient was dead upon arrival at the other hospital and the doctor was charged with criminal negligence. Although it was found that he had a duty to treat all patients arriving at the emergency ward under Quebec provincial law and that he had been reckless in not treating, the doctor was ultimately absolved of liability because it was not proven that the failure to treat had actually caused the death. Criminal negligence is even more significant because it may also lead to charges within the homicide provisions.

(vi) It is extremely rare for the administration of medical treatment to give rise to *murder or manslaughter*. However, questions arise at law in relation to murder in the case of cessation of life-saving treatment and the decision not to administer life-saving treatment. Manslaughter has been a consideration in cases where unreasonable treatments have been given which caused death, even though the doctor believed that the treatment was in the patient's best interests.

While conduct may fall within one or more of the Offences Against the Person, it may still be possible that no criminal liability will attach to it because a specific defence is available. All the usual defences apply in the treatment situation.

B. Defences

(i) The *Criminal Code* provides that everyone who performs a surgical operation is protected from criminal liability provided the operation is for the benefit of the person operated upon, the operation is performed with reasonable care and skill, and it is reasonable to perform the operation given the circumstances of the case. While it is clear that this defence applies to a surgical procedure regardless of who performs it or where it is performed, there is a great deal of discussion as to whether the defence is available only in the emergency situation or in all situations where surgery is deemed desirable. Furthermore, because of the benefit requirement, it is arguable that the defence does not apply to non-therapeutic interventions such as experimentation, unnecessary surgery, and non-meritorious procedures.

(ii) *The necessity defence* operates to exculpate someone from criminal liability when the breach of the *Criminal Code* is done to avert a greater evil. Thus, the administration of narcotics to kill the pain of a dying person, even though hastening death, may not be a crime because of the value of saving such a person from pain. Recent cases have used the defence to justify the use of illegal drugs, saying that the value of preserving life or health is paramount over all social values. However, the law is still unclear when it comes to a conflict between two lives as in the difficult situation of selecting one person to receive a scarce resource. Old case law suggests that in the absence of a self-sacrificing hero, all must go untreated. However, in terms of medical treatment one can take note of different situations in that the lives at risk are not literally all in the same boat. The moral and legal problem resides in determining whether *this* patient with poor prospects for survival may be, in effect, killed by withdrawing already instituted life-support apparatus in favour of *that* patient whose prospects for survival seem to be better. Even in the present state of the law, it would be perilous to argue that if a selection between patients would have to be made before committing a scarce resource, both or all of those patients would have to be denied the benefit of that resource presumably

because one must not choose. On the contrary, if the scarce resource or procedure be not already instituted and the patients' emergent conditions arise at about the same time, one must choose, for to withhold the resource or procedure wilfully from all really equates with wilfully neglecting to save whichever one who could be saved.

This completes the study of present criminal law relating to the administration of medical treatment. As has been indicated, the specific laws of the *Criminal Code* originated in Canada's first Code of 1892 and the present Code establishes a much broader scope of liability than was originally foreseen. It is apparent that legal, medical, and social developments have created a new reality which does not always conform with the older legal theory. The Commission appreciates that certain considerations and limitations of the present Code require reevaluation in light of rapid advancements.

PART IV

Considerations and Limitations of the Present Criminal Law

1. The Criminality of the Administration of Treatment

Is administration of treatment something which should be classified as a crime? On the contrary, are social values such that doctors and other dispensers of treatment should not be equated with the mugger, the violent hockey player, the drunk driver? Although there is no discernible consensus of opinion, there are three possibilities: complete decriminalization of treatment, criminality of treatment with necessary distinctions, and leaving things as they are. The Commission is of the view that the administration of treatment should still be within the ambit of the *Criminal Code* but that it should be distinguished from other acts giving rise to criminal liability in recognition of its particular characteristics of the special problems arising therein, and of the social utility attached to the acts.

First it must be clear that criminal conduct is outrageously offensive, injurious, or evil behaviour which adversely affects public interest of peace, order, security, health or morality.[290] This meaning must be considered along with the tests of criminality outlined by the Commission in *Our Criminal Law*.[291]

The fundamental question then is whether or not the administration of treatment causes harm. Criminal harm includes physical injury but also extends into the broader, intangible

realm of injury to values.[292] As discussed above, the criminal law in relation to treatment reaffirms many values associated with the security of the person, the preservation of life and health, and the freedom to perform vital social functions. Although it has been stated that treatment in a recognized form does not cause harm,[293] the Commission is of the view that this stance does not recognize that all treatments include some level of physical risk to health and that harm is a much broader concept than physical injury. Furthermore the criminal law recognizes that some harms are not significant in their effect either on an individual or the community. They are excluded from the *Criminal Code*. Criminal law recognizes varied responsibility for significant harms, depending on the probability of creation of harm when the conduct takes place. Thus, treatments of ascertainable beneficial value will not, by definition, be included within the meaning of harm. Certainly, the idea of what constitutes a crime varies as society's concept of good and bad behaviour varies. The Commission thinks that Canadian society is sufficiently interested in health and comfort to reaffirm the need for standards of care and respect for individual autonomy in the administration of treatment.

Individual and societal interests are reflected in the increasing incidence of private law suits for negligent treatment, accompanied occasionally with the demand that higher compensatory damages be reflected in criminal prosecution as a wrong to society.[294] While generally, the "interests of society will be subserved by holding a physician civilly liable in damages for ignorance and incompetence without imposing criminal liability, especially if he is a licensed physician acting with good motive",[295] there are situations where private remedies are inadequate and where the public moral character of criminal law needs to be reaffirmed. However, as in the past, the situations in the administration of treatment calling for criminal response will be rare. Although it has been suggested that this indicates the futility of criminal law in this area,[296] it may equally indicate the success of its deterrent force. This is especially so when it is appreciated that the decision to enforce a rule once enacted is generally based on considerations wholly different from those which gave rise to the rule. Prosecutorial discretion acts as a check on the imperfection of the law's reflection of contempo-

rary community values[297] and the reluctance to prosecute medical professional men has been expressly recognized in Canada.[298] However, during this period of declining prosecutions, society has developed other, less drastic means to control the administration of treatment through provincial licensing. The practice of medicine has come through a period of unheralded progress and increasing public prestige. Neither of these developments negates the utility of the criminal law in establishing moral standards and in ascertaining the limits of public interest.

Although quality control and public responsiveness may come through provincial licensing of health personnel, "there is no guarantee that the public interest is accounted for in formulating standards, since it is unrepresented in these groups".[299] Licensing bodies sometimes attempt to fulfill the mutually incompatible functions of protecting the public and of defending the interests of the group they represent. Also, it is fallacious to assume that professional knowledge necessarily implies expertise on moral and other values.[300] Criminal law is a recognized tool to outline the parameters of acceptable professional conduct and the scope of public review.

At the same time, the Commission appreciates the general effectiveness of existing provincial regulatory bodies in the establishment of a high standard of care. It also appreciates that law is not an all-purpose tool which can solve all social alarms, especially when superimposed upon persons who follow traditional custom.[301] These two considerations alone suggest the opportunity to differentiate the administration of treatment from other potentially criminal acts.

Historically, the *Criminal Code* has always based that distinction on the creation of specific justifications and duties. The distinction originated with the legitimization through licensing of the practice of medicine itself.[302] The differentiation of administration of treatment from other potentially criminal acts relates both to the nature of the act itself and to the attributes of those performing it.

Criminal law has always recognized that the administration of treatment is so important to social well-being, that care should

be taken to ensure that the law does not act as a deterrent to practice.[303] Medicine and other closely related disciplines are unique because as a matter of daily practice, they bring physical contact with another person. However, the law also reflects societal expectations that professional persons perform their duties with reasonable care and skill.[304] No compelling arguments have been advanced to challenge this long standing position.

The Commission further notes that calls for the "legalization" of medical treatment in England[305] refer to a situation where there is no differentiation between medical and other crimes. England has never enacted specific legislation in this area in contrast to the modern trend, with the result of a general confusion in criminal law.

Finally, in differentiating the administration of treatment from other acts, the Commission may be said, by some, to be in favour of conferring special privileges or creating a new protected class. This distinction however has always been made in fact and is generally supported. The *Criminal Code* separates many types of conduct which produce greater or lesser harm in order to achieve the broad objectives of the *Criminal Code*. The administration of treatment in that respect is afforded no further distinction than that given other types or kinds of conduct.

The Commission recommends:

(1) *that the administration of treatment continue to be regulated by the Criminal Code but be distinguished from certain other acts of application of force which are considered to be criminal.*

2. The Concept of Treatment

The concept of treatment is used in the *Criminal Code* to delimit the scope of personal duty and liability, of court orders, and of criminal immunity. Despite these broad functions, treat-

ment remains undefined in the Code. Because the meaning of treatment is notoriously elusive, this is not surprising; however, it tends to create uncertainty and confusion for those who administer "treatment", as to the legality and legitimacy of certain interventions.

It is clear that any definition of treatment should refer to the nature of the function, the group who will have the responsibility to administer it, and the methods of administration considered appropriate. Therefore, a definition can include the whole healing activity throughout society or be limited to the specific application of medical therapy by licensed personnel. The Commission understands that the healing process is interrelated through many sectors of society. In that sense, the assistance of a gym instructor in weight loss may be as beneficial as the dietary regimen prescribed by a physician. However, a definition of treatment for purposes of the *Criminal Code* should not purport to be exhaustive, but should be conceived in relation to and restricted to the particular purpose and intent of the Code. For this reason, it should clearly state the basis of a differentiation of treatment from any other interference with the person.

Treatment for the *Criminal Code* has five basic characteristics:

(1) it is a response to an individual health condition, resulting from disease, illness, disability or disorder;

(2) it is a process;

(3) it is oriented towards the therapeutic alteration of an individual's health condition;

(4) it is an application of force;

(5) it is limited to specific schools of healing.

"Treatment" is not a word of particular scientific significance. It is a term of social origin used to describe an interaction between persons or between persons and things. Thus, there exists the popular notion of how one "treats" his children or his dog.[306] However, the *Criminal Code* is not concerned with treat-

ment in this broad sense, but rather with treatment as a function within the health concept. Thus, treatment describes the particular response given to someone who is "sick". The condition of being "sick" refers to the presence of physical or mental disease, illness, disability or disorder in a person. These words are taken in their common, as opposed to medical, meanings and are inclusive.[307] Social acceptance of someone as "sick" depends on numerous factors,[308] the most significant being the interpretation of sickness itself. The tendency to label many social problems as medical and therefore categorized as "sickness" has been abating under severe criticism although the inclination remains.[309] For example, homosexuality has been labelled as a sickness and the classification of conditions such as alcoholism, drug addiction, obesity, and even cigarette smoking pose questions now. However decided, the categorization of someone as "sick" alters societal perceptions of that person's rights and duties.[310] Thus, the "sick" individual is in principle assured access to medical treatment; the failure to fulfill personal obligations and responsibilities may be justifiable; obligations may be relieved for a certain time; society may be justified in intervening to assist.[311] In this way, the characterization of the interaction between two individuals as administration of treatment may alter the rights and obligations of the parties involved.

Treatment is not only a response to a condition, most frequently sickness, but a system or process of handling that condition. The Latin derivative of treatment is "tractare" which means "to handle" or "to manage".[312] This basic notion pervades both medical and legal meanings so that treatment is a broad term covering all steps taken to ameliorate, remedy, or lessen the effects of disease, illness, disability or disorder. The word "treatment" is also used in medicine and law to denote the administration of specific therapies as the final step in a systematic approach to counteract disease following examination and diagnosis. The general meaning of the term however extends to "management and care for the purpose of combating disease".[313] Canadian, American and British case law illustrates a similar tendency in defining treatment broadly.[314] This wide general meaning was specifically adopted for the duty sections of the *Criminal Code*.[315] Most legislated definitions for purposes

of clarifying hospital functions and determining the scope of minors' consent, are similarly broad.[316] Of particular note is the definition in the *Uniform Consent of Minors Act* of "medical treatment" to include surgical and dental treatment, any procedure taken for the purpose of diagnosis, any procedure undertaken for the purpose of preventing any disease or ailment, any procedure, other than abstinence, undertaken for the purpose of preventing pregnancy, and also any procedure which is ancillary to any treatment, as it applies to that treatment.[317] These meanings all suggest that treatment is not only the application of specific therapies, but the total process of handling the individual including examination, diagnosis, and prescription.

The goal of treatment is the alteration of an individual's health condition, described as sickness. This orientation encompasses the traditional description of treatment as therapeutic, which denotes an orientation towards the cure, amelioration or lessening of the effects of disease, illness, disability or disorder.[318] The word "treatment" both in everyday language and in law carries the connotation of therapy. The Commission believes that this concept should not be disturbed. Further it recommends that where a medical intervention is intended to be of therapeutic benefit to the person on whom it is performed, it should be regarded as "prima facie" legal. However, some medical procedures involve an alteration of a health condition and are not therapeutic in that sense. The concept of treatment is then inappropriate to describe these procedures which are really a non-therapeutic intervention. These interventions are widely used for varied social purposes relating to birth control, religion, behaviour modification and experimentation, to name a few. The problem of their legality arose with the increasing availability and effectiveness of cosmetic surgery. The law stretched a little and reassured itself that this was within the traditional concept of therapeutic benefit because there was some psychological benefit present. The problem became even more acute with live donor organ transplants and, after initial use of the psychological benefit rationale, most courts called upon to decide the matter faced the reality that there was in fact no real therapeutic benefit to the donor. It should be recognized however that in certain cases there can be some real and significant psychological benefit to the donor. However, the operation was

not considered illegal because it was not contrary to public policy. Exactly the same rationale justifies non-therapeutic sterilization on consenting adults.

How can this legalization of non-therapeutic interventions be reconciled with the legal precedents we have outlined? There are two possibilities. First, from a historical point of view *section 45* with its requirement for therapeutic benefit may only apply to justify a medical intervention where the person is incapable of giving consent. If whether or not a non-therapeutic intervention is prohibited could be determined simply according to the general provisions of the *Criminal Code* and would ultimately depend on the current mandates of public policy. These, as we have stated, change.

The second approach to reconciling the carrying out of non-therapeutic medical interventions and the provisions of the *Criminal Code* does not require proposing that *section 45* is inapplicable to these. Rather the argument is as we have already discussed that *section 45* requires benefit and benefit is presumed when consent is present. The basis of such an argument is that the Code's fundamental premise is protection of the person and it is presumed that persons act self-protectively. In effect it is to propose consent and benefit as alternative rather than cumulative validating criteria of a medical intervention. This is probably what has occurred in practice as, for instance, before there was legislation dealing with live donor organ transplants, authorization of a court was not sought in relation to donation by competent consenting adults, which indicates that their consent was being treated a sufficient validation. There are, however, as we have seen, limits to the right to consent to the infliction of harm on oneself and again these limits are a matter of public policy.

In general it may be stated that the two most important factors in determining what is allowed are the degree and nature of harm and the purpose sought in the intervention. To the extent that consent is a validating factor in the absence of therapeutic benefit and to the extent that the interest promoted by consent has changed from being one of self-protection (or, as we have explained, therapeutic benefit) to one of self-determination

or autonomy some non-therapeutic interventions could be justified in law.

The Commission would thus recommend where the intervention is non-therapeutic, that the provisions of the *Criminal Code* should apply as for any other "wounding", but that justifications based on notions of public policy would be available to prevent some of them from constituting a criminal offence.

This differentiation between treatment and non-therapeutic intervention is used as the basis for specifically controlling or regulating certain procedures and for limiting the effects of the consent of minors. The *Criminal Code* should express an appreciation of this differentiation. This is especially so in exceptional cases involving minors and incompetents. It may extend to some specific practices related to sterilization, and human experimentation.[319]

Although the notion of therapeutic and non-therapeutic is broadly invoked in medical practice, the difference in fact between them is often obscured. Procedures clearly not related to disease, illness, disability or disorder, such as sterilization solely for birth control, appear to pose little difficulty. Problems arise in extreme cases where the taking of great risks may be warranted given the dire circumstances of a case.[320] In these situations, the probability of achieving a therapeutic result may be slim, yet the circumstances warrant the departure from established effective techniques. Transplantation of organs is one example where the likelihood of therapeutic gain may be low.[321] Yet the procedure is the last recourse in the handling of a difficult case. If the situation is such that some therapeutic benefit is possible in an otherwise desperate case, the taking of greater risks may be warranted. There is no ready solution to the overlapping borders of treatment and non-therapeutic interventions. Decisions should be made on a case-by-case basis.

It should be pointed out that "care" is included in the notion of treatment and non-therapeutic interventions. The corollary, however, is not true: treatment includes care, but care does not include treatment. This follows from the basic position in law that treatment must be administered with reasonable

knowledge, care and skill. Generally, "care" refers to the maintenance of a person's physical and mental condition to avoid deterioration and preserve basic comfort and functions.

All medical procedures designed to alter an individual's health condition involve an application of force upon the body of another.[322] This is so, even though there may not be a direct touching, such as with the x-ray and laser or the self-administration of a prescribed drug. Surgery, then, should not be in a different category from other medical procedures as all are applications of force. Although it may originally have been considered that surgery was a far more intrusive means to achieve a cure than other treatments and so deserved special protection,[323] this does not hold true today when drug and mechanical therapies may be equally intrusive. The distinction between surgery and other forms of medical treatments is an historical anachronism which is irrelevant for criminal law purposes.[324] Private law does not so distinguish.

As suggested above, the concept of treatment popularly applies to all healing activity. However, for the purposes of the *Criminal Code*, treatment should be differentiated from other applications of force only when the probability of its safe and effective administration is high. Although some people who administer treatment are so distinguished, not all receive general social recognition and approval. Without intending to castigate other applications of treatment, the Commission is of the view that treatment in the Code refers to the application of recognized methodology within schools of healing characterized by a generally accepted system of knowledge. This should include provincially legislated and recognized professionals who give treatment as described above. Legislation however is evidence only of the legitimacy of the application of treatment. In this way, popular home remedies and spiritual practices should not constitute "treatment", unless administered as a recognized therapy within established schools of healing.

While all of these five characteristics are significant to the concept of treatment in the Code, they are not easily assimilated into a statutory definition.

The Commission is of the opinion that the criminal law should not restrict the meaning of the word "treatment" to surgical and medical procedures but extend it beyond. This is consistent not only with provincial legislation, but with the trend of modern Canadian society and the more popularly received notion of treatment as including the active assistance of other than doctors. This concept reflects the basic reasoning for differentiation of treatment from other interventions. The implication of such a meaning clearly is that "care" and "experimentation" should be differentiated separately from "treatment" in the Code.

The question then remains whether or not this concept of treatment should be the object of a statutory definition. This definition could read in the following way:

> Treatment for the purpose of the *Criminal Code* is a process oriented towards the therapeutic alteration of individual health conditions, resulting from disease, illness, disability or disorder.

The Commission would appreciate receiving comments both on the desirability of statutorily defining treatment in the *Criminal Code* and on the above mentioned suggested definition.

Thus the Commission recommends:

(2) *that the concept of treatment be recognized for the purposes of the Criminal Code as a process oriented towards the therapeutic alteration of individual health conditions resulting from disease, illness, disability or disorder,*

(3) *that treatment and non-therapeutic interventions be distinguished by the criminal law, the former being considered as prima facie legal,*

(4) *that the provisions of the Criminal Code apply to non-therapeutic interventions as for any other acts involving the application of force and wounding but that a defence based on notion of public policy be available to prevent certain of them from constituting a criminal offence.*

3. Consent to and the Refusal of Treatment

Consent is of paramount significance to the legality of treatment and non-therapeutic interventions. Although it has always been recognized that an individual consent cannot make something legal that is otherwise illegal, the *Criminal Code* has recognized the effectiveness or not of consent for specific offences, such as assault.[325] The Code thus does not treat consent in a "uniform, analytical way" but according to the subject matter and type of behaviour in question.[326] Consent to treatment, then, must be specifically considered, especially given the uncertainty created in the present Code provisions.

A. Limits of Consent

The recognized limits of consent to treatment need to be ascertained as a matter of law. The common law has presumed that each man is the master of his own body.[327] While the individual is thus free to determine his own best interests, the criminal law has intervened in a self-protective way to prevent some interventions that are non-therapeutic.[328] This attitude is based on moral precepts of the Middle Ages which espoused the principle of the totality of human physical integrity.[329] The effect of this position has been to render uncertain the legality of non-surgical treatments, human experimentation, and some surgical procedures such as cosmetic surgery, and donor transplant surgery. This attitude considerably narrows the basic scope of individual liberty which the *Criminal Code* in other respects preserves.

The Commission has concluded that consent should be effective for all treatment and non-therapeutic interventions as discussed above and that an individual should be free to consent to whatever medical intervention he desired, although the availability of certain procedures may still be controlled through other means. The reasons are numerous. First, the public interest functions of the *Criminal Code* are not enhanced by the restriction of consent in this area. The interference with the private activities of consenting adults is not warranted by the

magnitude of the threat of physical harm. While all treatments may involve some "bodily harm" as understood in law, very rarely is this harm permanent and, even if it is, any real injury to the public as such is doubtful.[330] Also, public policy that recognizes the legality of some assaults according to historical interpretation in the *Criminal Code*,[331] has already been extended to surgical operations. There is no apparent reason why it should not also be extended to other medical interventions. Second, private law already recognizes the effect of consent to therapeutic and non-therapeutic procedures provided certain safeguards are met.[332] The developments in private law do not necessarily portend changes in the criminal law. However, they are often forerunners of criminal law change and always excellent indicators of judicial and public solutions to "demands of a changing condition of society for an expanding body of substantive law and for development of legal doctrine".[333] Third, ethical-religious attitudes have paralleled private law in recognition of the progress of medical science. While these norms do not go so far as to recognize the absolutely free disposal of one's body, they do approve of organ transplantation and experimentation within individual consent and certain external limits.[334] Fourth, consent in criminal law is not the best method to control certain procedures. The availability of resources and medical personnel, insurance policies, medical ethics and licensing, together with provincial legislative and regulatory enactments will have a natural effect on the availability of interventions to which one may consent. Furthermore, the nature of treatment is such that few will undergo it unless it is in their subjective best interest. Finally, many of the treatments presently excluded from protection in the *Criminal Code* are indeed accepted by society. Cosmetic surgery for beautification is popularized; sterilization is a recognized form of birth control; ritual circumcision is tolerated; experimentation is encouraged. All of these factors suggest that while there is a need for limits to treatment and non-therapeutic interventions, there do not need to be limits to the effect of consent.

The Commission is of the opinion that all treatment as defined above should be clearly lawful, provided there is consent among other things. The Commission recognizes however that there may still be specific procedures which can be considered

unlawful or that do require specific attention. These presently include the wilful infliction of death. Non-therapeutic interventions upon minors or incompetent persons should be guided by the general principles relating to incapacity to consent rather than the limits of consent itself. These questions will be discussed more extensively in the forthcoming Commission's Working Papers on sterilization and on human experimentation.

Consent is of singular importance to treatment, but is only one of the conditions which must exist for the ultimate legality of the procedure. It is not sufficient in itself. Moreover, there are some circumstances where the lack of consent will not render the administration of treatment unlawful. These circumstances refer to the emergency and other situations as established by law, and form an exception to the general rule requiring consent. They will be considered below. At present, it is sufficient to appreciate the limits of consent, its place in treatment, and possible exceptions to the rule requiring consent.

The Commission recommends:

(5) *that individual consent continue to be recognized as one of the essential conditions of the legality of the administration of treatment.*

B. Validity of Consent

Other limitations are imposed to the validity of consent. They pertain to the nature of consent as a free consensual act of will, informed and made with knowledge and understanding.

(i) *Consensual act of will*

There must first of all be a consensual act of will. Normally, consent must be sufficiently close in time to refer unequivocally to the procedure in question. Written acknowledgments or specific oral agreements are not problematical when applicable to the near future. There is, however, some controversy about statements of preference concerning treatment which are written to apply to a hypothetical event in the uncertain future, such as the "living will".[335] Although the "living will" idea is tradition-

ally restrained to the withholding or withdrawal of life-sustaining procedures in the event of a terminal condition and so more closely related to refusal than consent, the concept can really be applied more generally to any treatment. If the "living will" is considered as consent to treatment, then it may be effective as evidence of consent in a situation where a patient is incapable of expressing it, provided that, at the time of making the "living will", the requisite conditions otherwise required have been met.[336] Given the undeveloped state of the "living will" concept in Canada and its common applicability in the terminal illness case, the Commission will refrain from any conclusion here on its applicability in criminal law.

Second, there is also the question of those acts that can be taken to be indicative of implied consent. Canadian private law holds that a patient entering hospital thereby expressly or impliedly consents to treatment deemed necessary.[337] However, it has been held in other cases that consent cannot be implied if there is silence or an express refusal.[338] It has been suggested that, in criminal law, implied consent is the underlying rationale for the exculpation of a surgeon who operates to save the life of the unconscious patient.[339] This latter notion of implied consent as authorizing treatment in emergency cases is open to doubt in Canada because of the possible recognition of the defence of necessity.[340] However, the problem of the place of implied consent still remains. The subjectivity of the required consent in criminal law is still essential. Unless implied consent refers to a conversation or to circumstances pertaining to the particular treatment at hand, and to the attitude of the particular patient only and not the "reasonable person", it is open to serious doubt whether it is applicable in criminal law. Certainly, implied consent can never be utilized to authorize treatment, if a patient has expressly refused. If a patient is unconscious and therefore incapable of giving consent, the emergency exception may apply without reference to the somewhat unreal notion of "representative" or "implied" consent. These limitations seriously undermine the notion of implied consent so as to suggest that it has a narrow application in criminal law.

Third, for any treatment to be affected by consent, it must be within the scope of the consent given. "Scope" refers both

to manner and extent. Thus, the requirement for normal manner relates to the expectation of reasonable knowledge, care and skill in the administration of treatment. The extent of any consent is limited to what is inherent in and reasonably incidental to the normal administration of the treatment consented to. This requirement emphasizes that the consent is to a particular treatment and its ancillary procedures. The obligation to obtain consent is, therefore, a continuing one.[341]

(ii) *Freely given and informed*

Consent must be freely given. This means the absence of fraud as to the nature and quality of the act or identity of the actor, and the absence of duress.[342] Clearly the person administering medical treatment cannot be considered a person in authority. However, it has been suggested that more subtle coercions exist in the treatment environment such as the fear of pain and discomfort itself, the institutional setting, and the influence of other patients and staff.[343] Outside the treatment environment, parental influence may be such as to negative the effect of an unemancipated minor's consent. While the ultimate test is the subjective effect of these conditions on the individual patient, the Commission is opposed to coercive techniques which undermine the decision of competent persons.

The requirement of informed consent determines the extent of the duty of disclosure for those administering treatment. While knowledge definitely requires disclosure of information as to the nature and quality of the act about to take place,[344] it is not so certain that it also requires disclosure of its possible consequences, in the sense of known risks. In private law, it represents a modern medical-law development of traditional tort law.[345] The Commission does not consider it desirable to recommend that the content of information disclosure be legislated in criminal law. The present law requiring disclosure of the nature of the act, is included in the law of informed consent. It may ultimately be considered to include some information as to consequences, for purposes of the criminal law. In effect, the Commission's tentative recommendation amounts to this: failure to inform the patient of all the possible consequences would not obviate the patient's freely given consent for purposes of

the criminal law, even though such failure may still attract civil liability.

(iii) *Ability to understand and capacity*

The final requirement for valid consent is that there be an ability to understand the nature of the act. This does not mean that all the technical medical details of an intervention need to be understood, but rather that there be general comprehension or perception of what is about to take place.[346] The test is a subjective one: did the consenting person in fact understand the nature of the treatment? This is proved either by the consenting person admitting understanding, or by establishing that this person was capable of understanding.[347] Individual capacity is the key and overriding consideration of both consent and the refusal of treatment. Incapacity may be either a legal disability to consent to treatment such as minority, or the actual mental inability of someone to make decisions for himself.

Capacity to appreciate the nature of the act provides a variable test for minors, as opposed to arbitrarily setting an age. Although this may mean that a minor's consent may be recognized earlier for criminal rather than for private law purposes, the effect is to throw the balance desirably in favour of the legality of treatment.[348] This effect is similar to that of the *Uniform Medical Consent of Minors Act* which suggests the lowering of the age of majority for consent below the age of 16, if the minor is capable of understanding the nature and consequences of the act.[349] It is significant to note, however, that the consent is effective only for therapeutic interventions. Arguments have been advanced for an arbitrary age limit (usually 16) for ability to consent to non-therapeutic interventions.[350] However, for the purpose of consent to medical treatment in general, a minor's consent should be effective provided there is capacity. In the case of incapacity, parental or guardian consent may be sufficient for therapeutic interventions. On the contrary, non-therapeutic intervention decisions should be approved by a review board.[351] Thus, the Commission does not favour a specific, easily determinable age provision in the Code for consent to treatment, but prefers to maintain the flexible common law test, which is perhaps more difficult in litigated cases.

In relation to individual competence to consent to treatment, three major questions arise: is the individual competent to make his own treatment decisions? Who should decide the question of whether or not the individual is competent? If not competent, who should make those decisions for him?

The Commission adopts the well-established rule that everyone is presumed to be capable unless proven otherwise. Thus, if someone intends to intervene either without consent or against the express refusal of an individual, because he is thought to be incapable of deciding for himself, the onus is on the intervenor to prove that the individual is incompetent. Whether or not someone is competent depends very much on the test applied.[352] The actual tests used in any case are often unknown because there is no standardized approach. The determination is often based on the subjective evaluation of persons assisting a patient. Increasingly, however, standardized approaches are being requested for non-therapeutic and highly intrusive interventions.[353] In the face of competing interests, a finding of incapacity has sometimes facilitated the imposition of widely-held social values over a contradictory individual's stated interest.[354] The mentally ill, mentally retarded and institutionalized persons have been generalized as being incapable.[355] The Commission believes that an individual should be found incompetent only if he is unable to understand and appreciate the nature, risks, benefits of and alternatives to treatment. The reasonableness of the choice or the quality of the thinking process is irrelevant provided this basic ability is present.[356] The fact of mental illness, mental retardation, or commitment to an institution should never, of itself, be sufficient to conclude that the individual is incompetent.[357] The Commission is aware that some treatments should arguably require apparent subjective understanding and awaits reaction on this issue.

The ultimate finding of incompetence should be made by a court. The law has always recognized the seriousness of taking away an individual's right to decide what shall be done to his person. There is no reason why an exception should be made in the medical environment. This is the procedure presently adopted by most provincial legislations[358] and is the surest guarantee of protection of self-determination and personal security.

The mentally ill, mentally retarded and institutionalized persons should not be discriminated against in this respect by allowing lesser procedures to replace a full judicial hearing. Incompetency is not a matter to be determined for reasons of expediency. Although the test of competency may be administered by one or two independent doctors or skilled personnel, such findings are not conclusive, but only evidence to be considered along with other facts by a judge who will have to decide the ultimate issue. Arguably, these hearings should be held in a unified Family Court as suggested in this Commission's Report to Parliament, Family Law;[359] however, a superior, county or district court should exercise jurisdiction in the absence of such a court.

Once someone is found incompetent, who should decide what is in his best interests? Traditionally, the family has decided. This should still be so in the case of therapeutic treatment where the best interest of the incompetent is pursued. However, it is increasingly suggested that the family may express interests which may not always adequately represent the best interests of the incompetent, especially with regard to non-therapeutic interventions.[360] While family interests must be outweighed only by compelling interests, the proper forum for so deciding must objectively weigh all considerations with predominant emphasis on the best interests of the incompetent individual. Recent cases on the cessation of therapy administered to comatose patients have recommended either a committee[361] or a court[362] as the appropriate forum. While both procedures have been the focus of considerable debate,[363] the Commission favours the use of administrative boards.[364]

The Commission envisions a board who would be responsible for all decisions involving non-therapeutic interventions on incompetents. Jurisdiction could conceivably be extended to include decisions pertaining to other specific procedures as expressed by the legislators in statutory enactments.[365] The Lieutenant-Governor-in-Council or the Minister of Health of a province could appoint these boards and establish them as geographically required in the province. The Commission fully appreciates the dimension and the practical consequences of this suggestion and invites provincial response.

The Commission recommends:

(6) *that what constitutes a legally valid consent to treatment, for the purposes of the criminal law, be determined according to the standards evolved by the case law;*

(7) *that treatment shall not be administered without the consent of the individual treated unless there is, or has already been a finding of incompetence or another specific exception recognized by law;*

(8) *that the judicial finding of incompetence be made by a Superior, District or County court;*

(9) *that decisions regarding non-therapeutic interventions on incompetents be made by a provincial board established for this purpose.*

C. The Refusal of Treatment

The requirement of consent infers the corollary right to refuse treatment. Specific comment on such refusal is needed in relation to criminal law, because of the predicament it creates. What is the extent of an individual's right to refuse treatment in the face of societal concern, parental or otherwise? Does the doctor's duty to treat end, either permanently or temporarily, with such refusal? Does an individual refusal absolve the doctor from criminal liability, in the absence of legislative or judicial pronouncement? A basic position needs to be established for the *Criminal Code*.

Refusal may be either the absolute denial of authorization for any intervention whatsoever or the limitation or qualification of a consent to any particular treatment. As suggested above in the case of the "living will", it may be possible to express such refusal prior to actual knowledge of the need for treatment. The refusal of life-saving or prolonging therapy, particularly in terminal cases, is a problem of its own and is discussed in a forthcoming Working Paper.[366]

The right to refuse medical treatment involves a delicate balancing of individual and state interests. Individual interests

are based mainly on the principles of the inviolability of the body, of the right to self-determination and the autonomy of the person. They interact with the protection of privacy, freedom of religion, freedom of contract, and the right not to be deprived of security of the person except by due process of law. State interests include the power to provide for the health, welfare and safety of society, the *parens patriae* power, and the protection of third parties. The composite of these interests favours recognition of the right to refuse treatment.

The *Criminal Code* has preserved the basic common law approach which upholds the right to refuse treatment except where expressly otherwise provided. Specific exceptions to the right of refusal include the compulsory treatment for alcoholism or drug use[367] and the ordering of a mental examination.[368] Noticeably, the *Criminal Code* only provides for the ordering of the custody of insane persons[369] and the custody and care of the mentally ill,[370] thus implying the continuation of their right to refuse treatment. The right to refuse intrusion on one's body has been upheld in the giving of blood samples[371] and in undergoing surgery for the purpose of obtaining evidence.[372] In these cases, the fact that there had been a refusal was not admissible at trial.[373] Moreover, the refusal of life-saving treatment by the victim of a criminal act, does not undo the causal connection between subsequent death and the murderous act.[374] The approach of the *Criminal Code*, then, is to uphold an individual's right to refuse intrusion on one's body, unless there is a specific statutory exception.

The Commission has concluded that the preponderance of legislative, judicial, professional, and public attitudes favour the recognition of the right to refuse treatment. The general approach of the *Criminal Code* is supported by the common law dealing with private matters. The overwhelming majority of these cases support the right of a competent adult to refuse treatment.[375] This right is also preserved in the medical Code of Ethics[376] and recognized in hospitals' patients' bills of rights.[377] Surveys of nurses indicate acceptance of the terminal patient's right to refuse treatment,[378] and medical opinion has favoured its recognition.[379] Informal surveys report that "the general population [has] demonstrated growing and overwhelming support

of legislative affirmation of an individual's continuing right to guide his medical care and to refuse treatment''.[380] The denial of a right to refuse treatment has been suggested only in relation to the likely result of death. It is based on the priority of the preservation of life over the autonomy of the individual.[381] Without commenting on the euthanasia situation, it is otherwise recommended that the principle of individual choice be respected in all cases, unless specific exceptions are made by legislation.

Given those facts, the question, then, remains whether the right to refuse treatment needs to be expressly recognized in the *Criminal Code*. In the Commission's view the answer is yes.

Although the right of refusal is broadly recognized in law and in opinion, this may not be so in practice because of the fact that the patient's refusal is often ignored. Paternalistic forces sometimes overpower the individual's right to autonomy, when what appears as a benefit to others is refused by the individual. Several mechanisms operate to produce this result.[382] A doctor's effort is directed towards saving lives and studies indicate that a patient's prognosis and functional ability are predominant over expressions of consent.[383] Individual decisions going against these indicia are often considered to be made by someone obviously incapable, even though the law respects the right of an individual to make unreasonable or foolish choices.[384] Specific recognition of the individual's right to refuse treatment may not change the realities of administration. However, it would serve to clarify present ambiguities.

It has often been stated that a doctor may not substitute his will for that of the patient;[385] but when it is done, it is often countenanced by law. There is a basic presumption that everyone desires to be protected from harm and that nobody wants to die.[386] While this principle is rarely invoked on its own, it is reflected in the defence of necessity and in arguments on the scope of the surgical justification. It is possible through either of these defences to justify any intervention against the express wishes of an individual provided a net benefit is achieved. The result is that one cannot say when an individual's choice will, or will not, be respected. Legislative recognition is thus neces-

sary to establish the limits of these defences, as they affect individual autonomy.

Finally, legislative enunciation of the right would further assist to clarify the scope of the duty of those who undertake to treat or who provide necessaries. While at civil law the signing of a waiver may clearly end the doctor's obligation arising on a contractual basis this is not so in criminal law unless the consensual aspect is specifically recognized. The right of refusal needs to be given parallel effect in criminal law, so that the limitation or termination of an obligation to treat depends on the scope of the refusal.

The Commission recommends:

(10) *that the right of a competent adult to refuse treatment be specifically recognized by the Criminal Code;*

(11) *that treatment shall not be administered against an individual's refusal, unless there is a finding of incompetence or an exception recognized in law.*

D. Exceptions to the Requirement of Consent

In addition to the case where incapacity negates an expression of individual will, there are two further situations where consent to treatment or to cessation of treatment is either impossible or inappropriate. These are the emergency and the state enforced compulsory treatment situations. Although it is sometimes suggested that these cases are examples of implied consent, they really are exceptions to the requirement of consent in the sense of a privileged intervention.[387]

It is clearly desirable that medical treatment be administered to individuals in an emergency situation, even though it is impossible to obtain consent because a patient is unconscious or temporarily incapable of expressing it. The Commission is convinced that the general attitude overwhelmingly favours a presumption of saving life or health in a crisis.

However the Commission believes that a competent and conscious patient should retain the right to refuse treatment in an emergency. The definition of an emergency and the attendant duties will be discussed below.

There are other situations recognized by both federal and provincial law rendering treatment compulsory. They have to do with public health,[388] administration of justice,[389] and mitigation of damages.[390] It is not intended to delve into the legitimate scope of state authorized treatment at this time, except to point out that specific legislative enactments do form a permissible exception to the consent requirement.

The Commission recommends:

(12) *that treatment can legally be administered to an individual without the necessity of obtaining his consent, in a situation of emergency where that individual is incapable or unable to express his consent;*

(13) *that the right of a competent individual to refuse treatment in a situation of emergency be recognized.*

4. Standards of Administration of Treatment: Practice by the Qualified and Unqualified

In addition to the requirement of consent, it is generally assumed that the legality of a treatment intervention depends upon its being performed with an acceptable level of skill, knowledge and care. This is not only expressly required in the *Criminal Code* duty of those administering treatment, but is the basis of the wrongful act in criminal negligence. The Commission is confident of the utility of such standards and in this section wishes to clarify the minimum levels required for criminal law.

In determining the acceptable standard of conduct for the administration of treatment, the overriding criteria are that it be fair, reasonable, and reflective of societal expectations. It is,

therefore, useful to consider separately the administration of treatment by the qualified and unqualified. By "qualified" is meant certified by provincial licence to practice any one of the health disciplines.

A. The Acceptable Standard for the Qualified

For qualified persons, it is established that a "reasonable knowledge, skill and care" comprehends their presumed capability and therefore is that knowledge, skill and care possessed by the average licensed person trained to do the same act. Neither the highest nor the lowest standards are expected. By "average" is usually meant the customary practice of other similarly situated members of the profession.[391] The Commission rejects the specific use of the word "average", because of the implied impossibility of half of the group to comply. Instead, it favours use of the word "competent" to denote a basic level of acceptability. This standard presents an acceptable basis of conduct which is flexible. Particular difficulties arise however with the practical application of this standard in high risk cases, and with specialists.

When treatment involves known risks, the standard of care is generally higher than when "no such risk can be reasonably anticipated."[392] Experimentation or innovative therapies must then be administered with greater precaution than known and accepted treatments. A flexible approach is desirable with a basic minimum standard.

A specialist is represented as having special skills and additional training. It is reasonable that he or she should be expected to perform at a level reflective of that additional capacity. Thus, the Supreme Court of Canada has said that a specialist must "exercise the degree of skill of an "average" specialist in his field".[393] With the exception of the average requirement, there appears no reason why this principle should not be equally applicable in criminal law.

There are other issues in standard of care which are beyond the scope of this paper, but one further development should be

mentioned. It has been suggested in the United States that a "professional" standard of care be adopted over a reasonable standard of care. In this way, ". . . practices approved by the profession, not necessarily those customarily followed by its members, would be controlling".[394] While this approach has numerous advantages, the state of standardization for health disciplines in Canada is such as to make the idea difficult if not infeasible at the present time.

The Commission recommends:

(14) *that the acceptable minimum standard required for a qualified person in the administration of treatment be the knowledge, skill and care of a competent similarly qualified person performing the same act in similar circumstances.*

B. The Emergency Situation

The reasonable standard rule indicates a willingness to recognize relevant circumstantial factors as affecting the standard of care. An emergency is also a relevant factor, dependent on situation and time. In situations of stress and urgency where appropriate facilities or personnel are unavailable, it may be impossible to render the assistance which might be expected in normal circumstances. The question then is, should a different standard of care be required in emergency cases?

The *Criminal Code* presently provides an exemption from the requirement of reasonable knowledge, skill and care "in cases of necessity".[395] Assuming that "cases of necessity" includes the emergency situation, why was the reasonableness standard excluded in these cases? Historically, the reasonableness standard was inflexible. A specific exception was thus required, to allow for treatment by the unskilled in an emergency.[396] Also, it is possible that the moral duty upon those who are qualified to administer treatment, to assist in an emergency was considered to render the assistance compulsive or involuntary and therefore not subject to a societal expectation of standard of behaviour. Finally, the exemption might have been intended to encourage the rendering of emergency assistance.

For whatever reason, this exception is difficult to rationalize today.

The flexible reasonableness standard invokes consideration not only of the special circumstances of a case, but also the qualifications and capabilities of the individual involved as compared with persons of the same group who are similarly qualified. Thus, it is fair to expect someone specially trained to administer emergency first aid to perform with greater skill, than a dentist happening upon an emergency scene without special knowledge of accident victims. Some provinces have already enacted legislation exempting physicians from civil liability for rendering services in an emergency situation except in case of gross negligence.[397] This is, in effect, the applicable standard of the criminal law. Maintaining the reasonableness requirement in emergencies would be consistent with provincial goals. Common sense tells us that in these situations, one is expected to perform with the reasonable knowledge, care and skill of the group to which one belongs, considering all the facts of the case. This is the accepted approach in civil law[398] and is reflective societal expectations.

The Commission recommends:

(15) *that the standard of reasonable knowledge, care and skill recommended above apply also in emergency situations, taking in consideration the particular circumstances of the case.*

C. The Acceptable Standard for the Unqualified

The general approach towards standards of treatment is that one must exercise a minimum level of knowledge, skill and care with higher standards according to individual qualifications. The minimum level is based on the nature of the activity. More dangerous conduct requires greater care and skill. The original idea, still evident in the *Criminal Code*, was that there was to be no differentiation between the qualified and the unqualified.

The rationale for non-discrimination was based on the facts that unqualified healers had existed long before licensure. To

create a heavier penalty for the unqualified would have meant that many, in isolated areas, would have had to go without any assistance. However, even in the earliest discussions, opinions diverged as to whether the administration of treatment by the unqualified should be subject to strict liability.[399] The original and legislated intent indicated non-discrimination based on the honest exercise of one's knowledge, skill and care within reasonable limits. The evolution of case law shows that the approach gradually adopted towards the unqualified became one of strict liability.[400] This bifurcation developed along with the growth of modern medicine as a truly scientific discipline. The approach is manifest in the application to unqualified persons who administer treatment of the standard of care of the average qualified medical practitioner.[401]

The original non-discriminatory intention was laudable and appropriate. However changed circumstances and attitudes have resulted in an unfair burden being placed on an unqualified person who administers treatment. It is of course highly desirable that persons do not engage in potentially harmful conduct, when someone with appropriate skills is available: It is equally desirable that the principles of the criminal law be applied consistently. Mr. Justice Dickson of the Supreme Court of Canada wrote recently: "It is essential for society to maintain, through effective enforcement, high standards of public health and safety. Potential victims of those who carry on latently pernicious activities have a strong claim to consideration. On the other hand, there is a generally held revulsion against punishment of the morally innocent."[402]

The utilitarian concern for optimal health care is protected in provincial legislation which imposes penalties for unlicensed activity within the health discipline statutes. Public interest is further protected by a complex control system for drugs and other dangerous substances, thus reducing the likelihood of administration by unqualified personnel. Many people take advantage of unlicensed personnel to assist with common ailments and are encouraged to do so by the great numbers of self-help books. It would be manifestly unfair of society on the one hand openly to countenance certain behaviour, but on the other hand

to then apply unusually strict standards, when something goes wrong through no fault of the actor.

There should be no criminal liability if an individual does not misrepresent his or her qualifications and if someone agrees to a popular therapy administered without foresight of harm and according to standards of reasonableness. The reasonableness standard applies both to the initial undertaking and to administration. Naturally, reasonable persons do not carry on activities beyond their skills when more appropriate personnel are available. They do not administer drugs about which they know nothing. If some people purport to have qualifications which they do not in fact have, then they should be judged as they have led society to believe, and the stricter standard should apply.

The Commission recommends:

(16) *that the acceptable minimum standard on the unqualified person in the administration of treatment be that of the reasonable ordinary person and not that of the qualified person;*

(17) *that where a person holds himself out as having certain qualifications and where the public or the individual treated rely on these qualifications, that person be judged according to the standard of the qualified person he represented himself to be.*

5. The Mental Element

There is considerable confusion as to the requirement of the mental element in the administration of treatment. Although this is a problem not peculiar to treatment, but general in the *Criminal Code*, reasons for the confusion can be isolated.

The purpose of offences concerning the administration of treatment is dual: socially undesirable conduct which violates physical integrity or causes harm must be punished; high standards of public health and safety must be maintained. By

attempting to achieve both purposes through the same means, the Code confuses crimes with public welfare or regulatory offences.[403] Because the mental requirement for each of these categories of offences is different, confusion inevitably follows. The situation is further complicated by the non-differentiation of the qualified from the unqualified.

The Commission considers unskilful, dangerous activity as a direct threat to fundamental values pertaining to individual integrity. There are many people who engage in potentially dangerous activities on a regular basis. It is desirable that unskilled persons who do so incur the risk of criminal liability because of the obvious harm which can result. The administration of treatment by the unqualified is an example of this type of activity. Yet it is not an example which needs to be differentiated from other dangerous acts which any person could perform. Harmful acts committed by unqualified persons should fall within the general category of crimes against the person, with the mental culpability based on the usual rules.

Administration of treatment by a qualified person is a different situation. For one thing, it is not considered to be wrong unless it falls below a certain standard or unless individual interests are violated. The majority of persons who administer treatment are qualified. They represent a special category of person, because they are recognized as interacting in a unique role and as performing a specific activity. When acting in this role, the primary societal concern is with the protection of the public through the promotion of high standards of care. Generally, treatment by qualified persons is socially desirable.

Cases involving qualified health personnel indicate a tendency to presume a culpable state of mind from the grossly negligent nature of an act. This tendency is reinforced by the difficulty of proving mental culpability in the ordinary exercise of one's skill or calling. Certainly, medical judgments must be made honestly or in good faith.[404] This could be evidenced through consultation with other professionals. These realities must be reflected in the *Criminal Code*.

As already outlined in this document, a defence of mistake of fact negatives mental culpability, provided that the mistake is honest and, sometimes, reasonable. The "reasonableness" requirement has been invoked in the past to disallow the defence in the case of honestly held religious beliefs.[405] Although the Commission generally believes that the scope of public danger from the exercise of religious belief and the effectiveness of the criminal punishment in this area are limited,[406] it does not envision a broad protective clause based on religious belief. Instead, the Commission urges judicial recognition that "reasonableness" is not based on simple majority views. Judicial, legislative and private recognition of a belief as permissible is a significant factor. Incorporation statutes governing the practice of medicine, federal income tax laws and accident and health insurance policies, all indicate societal acceptance and toleration of religious practice and belief which must also be evidenced in criminal law. Moreover, freedom of religion is asserted to be fundamental by section 1 of the *Canadian Bill of Rights*.

6. Safeguarding Persons in Danger: The Duty to Treat and Emergencies

It is clear that in order for the *Criminal Code* to fulfill its function of preserving life, health and other fundamental values, it may be necessary to impose legal duties upon some persons. For this reason, parents, married persons, and persons in charge of others have been obligated to provide necessary medical treatment respectively to children, spouses and helpless individuals. Persons who undertake dangerous acts, including medical treatment, have to do so with reasonable care and skill. Finally, as we have seen, once an act is undertaken, it has to be completed if failure to do so might be dangerous to life. The Commission entertains no doubts that these duties are essential to achieve the purpose of the Code. Moreover, are they broad enough? Are they sufficiently clear so that obligated persons understand their responsibilities? Do they reflect societal expectations? Are they fair and reasonable?

A. The Traditional Protections

The obligation of parents, spouses, and persons in charge to provide medical treatment is correlative of the right to medical treatment and to security of the person. This obligation reinforces the universal right to health care.[407] Although this has usually been interpreted in Canada to mean equal access to health care services through government health programs,[408] the *Criminal Code* looks to protective relationships such as the family in order to perfect the right for those who, through age, institutionalization or disability, cannot independently gain physical access to health services. Not only does this reinforce present provincial and federal statutory obligations,[409] but it, in some instances, extends them. For example, it theoretically assures that treatment will be made available to involuntarily detained mental patients. Nonetheless, the criminal aspect is maintained at two levels. First, by requiring the provision of medical treatment which is necessary and not merely adequate and secondly, by making failure so to provide an offence only in case of dire circumstances or where life or health is permanently endangered. Although prosecutorial discretion may tend to undermine the performances of this duty, the Commission does favour its retention.

The duty upon those who undertake dangerous acts, including surgical or medical treatment, has already been discussed. It was suggested that the practical non-differentiation between professionals and non-professionals created an onerous burden for the latter group. Although those with special skill *were* indeed differentiated in the early suggested Codes,[410] our first Code joined the two, probably because of the common dangerous nature of the act. The Commission notes that the *Criminal Code* does consider that certain disabilities affect the criminal nature of an act. The defence of insanity and provocation are good examples. Similarly, the *Criminal Code* should reflect levels of ability, if socially recognized training makes a realistic difference in one's knowledge, awareness and skill when undertaking an act. In fact, this would merely codify existing criminal and private case law and accepted societal opinion.

Another problem that needs consideration is whether the duty attaches only at the time of the performance of the dangerous act or rather as soon as there is a professional undertaking. There is uncertainty at present because the reasonableness requirement appears to relate only to the actual administration of treatment. However the duty does arise upon the undertaking. Is the expectation that doctors will do everything that is reasonably required after they have accepted a patient? Or is it only that they administer treatment reasonably? The decision of whether and what medical treatments should be administered is primarily a question of medical judgment. Generally, any requirements of specific treatments are best dealt with under provincial legislation, rather than by a general reasonableness clause in the *Criminal Code*.[411] Also, any specifically dangerous or hazardous treatments may be the subject of special legislation.[412] Presently, the duties arising from such legislation may give rise to a charge of criminal negligence. Although it is desirable that the Code make clear its expectation that treatment be in accordance with federal and provincial laws and professional standards, that is not the real purpose of the obligation under discussion. The goal of the duty here is the performance of dangerous acts with reasonable knowledge, care and skill and the completion of what is reasonably required upon an undertaking to treat. No attempt is here made to impose affirmative action outside the established relationship.

The Code does impose an obligation to act within the doctor-patient relationship, if failure to do so may endanger life. With the possible exceptions of an obligation to continue life-support systems[413] and to provide treatment when resources are not available, this obligation must be maintained as reflective of the requirement that doctors should not abandon their patients, once the patient has relied on them for care. It also supports the right to health care services, by requiring the doctor who refuses to treat to secure alternative sources if failure to treat may be dangerous to life.

The exceptional allocation of scarce resources requires implementation of a mechanism which respects the individual's right not to be deprived of life or of security without due process

of law. Unfortunately, further comment on the allocation problem is beyond the scope of this Working Paper.

The Commission is further of the opinion that the duties of reasonable knowledge, care and skill and of fulfilment of an undertaking should not only apply when life is endangered. The Code seeks to preserve life *and* health. To delete health from these important obligations is not only inconsistent, but undermines the protection given the person in the Code.

The Commission recommends:

(18) *that the substance of the present provisions of the Criminal Code concerning duties tending toward the preservation of life be retained;*

(19) *that these provisions be extended to apply also where there is a danger of permanent injury to a person's health;*

(20) *that the Criminal Code make separate provisions for the general duty of reasonable knowledge, care and skill in the performance of dangerous acts and for the duty of reasonable knowledge, care and skill in the administration of treatment by qualified professionals;*

(21) *that the duty of reasonable knowledge, care and skill apply upon the undertaking of the administration of treatment;*

(22) *that an exception to the duty to undertake or to continue a treatment be recognized when resources are not available.*

B. The Evolution of the Duty in Emergency Situations

Criminal and tort law have persistently been reluctant to found liability on omissions or failure to act. This attitude is based on ancient concepts of conduct[414] and was the subject of considerable controversy when the first criminal codes were enacted.[415] The prevailing view was thought to preserve the ideal of individual liberty and of independence and self-reliance.[416]

An outcome of this principle is that no liability will attach for failure to render assistance to persons in emergency.

This traditional attitude, however, is changing. Canadian legislative opinion has increasingly supported an affirmative duty to act to save persons in danger or has encouraged such action. Most outstanding is the legislation in the province of Québec which assures everyone whose life is in peril the right to assistance and which imposes a duty to assist on every person, unless it involves danger to himself or a third person or there is another valid reason.[417] The legislation is similar to the criminal laws of most European countries,[418] and the law of some American states.[419] It is backed by compensation to rescuers for injury or death.[420] Other provinces have encouraged the rendering of emergency assistance by medical practitioners by enacting "Good Samaritan" laws, whereby no liability attaches to treatment administered unless it is grossly negligent.[421] Furthermore, most provinces specifically provide that the rendering of emergency assistance does not constitute the practice of medicine.[422]

Judicial opinion has also moved towards the requirement of rendering assistance in an emergency, especially when special relationships exist. Potential criminal liability was found when a doctor did not render emergency services while on call in the emergency ward of a hospital, contrary to provincial statutory duty.[423] The master of a ship must come to the aid of a passenger who has fallen overboard.[424] Hospitals with emergency rooms have been required to render emergency aid to all persons in peril who arrive at the hospital for assistance.[425] These cases indicate a certain degree of judicial willingness to recognize a duty to aid, where the public expects and relies on such aid in an emergency.

The doctor-patient relationship has usually been considered voluntary. The Code of ethics of the C.M.A. states that a physician has the right to refuse a patient, except on the basis of colour, religion or political belief.[426] However, the Code further provides that the right of refusal does not exist in an emergency and that a physician should render all assistance possible where an urgent need for medical care exists.[427] Despite these moral

obligations, it was documented, in the United States, in the 1960's that the overwhelming majority of doctors would not stop to render assistance when travelling in the community.[428] As a result, the "Good Samaritan" laws were passed; but the perception has been that the problem is not solved. Québec and the state of Massachusetts have gone one step further by regulating the ethical obligation of a physician to render emergency services.[429]

Finally, it is inadequate to use nineteenth century philosophy to solve modern problems. The extreme individualism of those times has been replaced by a social interdependence which is exhibited in collectivist social legislation. Furthermore, the Commission thinks that the general public reasonably expects assistance when available in an emergency.

What, then, should be the approach of the criminal law? Should the Code impose an affirmative duty to render aid in an emergency either upon physicians, professional health personnel, or the general public? Consideration of this course of action is not new to Canadian law, although opinion either way is noticeably scant.[430]

The Commission appreciates that "laws are statements of public policy and opinion as well as instruments for courts to implement and police to enforce. The very passage of a law is an act of public definition of what is moral or immoral."[431] It is cognizant of the *Universal Declaration of Human Rights* which states that all human beings should act towards one another in a spirit of brotherhood.[432] In recognition of these principles and of legislative, judicial, ethical and public opinion, the Commission has concluded that everyone should be obligated at criminal law to render assistance in an emergency.

The effect of this duty would be to require members of the public as well as physicians to provide emergency aid when confronted with an emergency. Physicians would thus be required to give medical aid in all circumstances, both inside and outside the hospital. An emergency, although incapable of precise definition, means a set of circumstances which immediately threatens a person's life or is likely to cause serious and per-

manent injury, if no immediate professional assistance is given. The obligation would not establish a doctor-patient or other relationship in the sense of requiring continuing care. The physician or passer-by would be obligated only to ensure that the patient receives reasonable treatment or care in the interval between the emergency and the provision of relief services. Because of the exemption in the Medical Acts,[433] there is little likelihood of problems, should an out-of-province physician render assistance. In the case of an emergency caused by a criminal act, any injury to the assisting person should be compensated.

Although the Commission had considered limiting the duty to physicians and other health personnel because of the existing strong moral obligation upon doctors and other health professionals and the special placement of trust upon these people by the community, it has favoured a broader duty in appreciation of existing legislation and the principle involved. The Commission welcomes public response on this issue.

The Commission recommends:

(23) *that the Criminal Code recognize the general duty to render assistance to an individual in danger where the life or health of that person is seriously threatened and the circumstances are such that the person is aware of the emergency and can provide immediate assistance without undue hardship to himself.*

PART V

Proposed Solutions and Suggested Reform

1. Summary of Recommendations

In this Working Paper, the Law Reform Commission has primarily sought to preserve societal interests in the preservation of life, health and personal integrity and in keeping dynamic and competent healing professions. Through an examination of the present law and of contemporary medical and ethical standards, it has been shown that the criminal law does not accurately reflect either the expectations that individuals have when they seek and receive treatment, or the assurances of immunity that professionals desire before undertaking treatment. A reconciliation of this differential can be achieved through changes in the present law according to the following principles.

The administration of treatment by qualified personnel in the pursuit of continuing life and health is to be differentiated from other intrusive acts upon the body of another. The value of treatment makes its administration special among offences against the person. However, there is still the need to assure that this everyday activity be performed according to precise and ascertainable criteria in the *Criminal Code*.

Individual rights to security of the person and privacy must be protected by the requirement of a knowledgeable consent and recognition of the right to refuse treatment. If, through either legal or factual disability, an individual is unable to consent, his/her interests must be fairly and accurately represented

and protected according to usual legal procedures. However, there are situations, such as an emergency, when assisting personnel should be able to act to preserve life and health despite the absence of consent.

The differentiation of treatment from other offences against the person is based primarily on the recognition of the competence and high ethical standards of our healing professions. At the same time, realistic expectations of standards of professional care must be implemented. This involves the adoption of a flexible standard based on reasonableness and on the particular circumstances of each case.

Because of the dependence of individuals upon health care services, the legislators have the obligation to ensure that essential needs will be met, especially if an individual is unable to secure the service himself. This obligation has devolved to professionals who willingly undertake to provide treatment; but the role of legislators continues. Thus, the *Criminal Code* has traditionally required persons to provide treatment if they have undertaken to do so or if they are responsible for disabled persons. These obligations should be maintained and expanded, if necessary, to guarantee all Canadians a basic security of the person.

These broad principles may best be effectuated through implementation in the *Criminal Code* of the following recommendations:

(1) that the administration of treatment continue to be regulated by the *Criminal Code* but be distinguished from certain other acts of application of force which are considered to be criminal;

(2) that the concept of treatment be recognized for the purposes of the *Criminal Code* as a process oriented towards the therapeutic alteration of individual health conditions resulting from disease, illness, disability or disorder;

(3) that treatment and non therapeutic interventions be distinguished by the criminal law, the former being considered as prima facie legal;

(4) that the provisions of the *Criminal Code* apply to non-therapeutic interventions as for any other acts involving the application of force and wounding, but that a defence be available to prevent certain of them from constituting a criminal offence;

(5) that individual consent continue to be recognized as one of the essential conditions of the legality of the administration of treatment;

(6) that what constitutes a legally valid consent to treatment, for the purposes of the criminal law, be determined according to the standards evolved by case law;

(7) that treatment shall not be administered without the consent of the individual treated, unless there is or has already been a finding of incompetence or another specific exception recognized by law;

(8) that the judicial finding of incompetence be made by a Superior, a District or a County Court;

(9) that decisions regarding non-therapeutic interventions on incompetents, be made by a provincial board established for this purpose;

(10) that the right of a competent adult to refuse treatment be specifically recognized by the *Criminal Code*;

(11) that treatment shall not be administered against an individual's refusal unless there is a finding of incompetence or an exception recognized by law;

(12) that treatment can legally be administered to an individual without the necessity of obtaining his consent, in a situation of emergency, where that individual is incapable or unable to express his consent;

(13) that the right of a competent individual to refuse treatment in a situation of emergency be recognized;

(14) that the acceptable minimum standard required from a qualified person in the administration of treatment be the knowledge, skill and care of a competent similarly qualified person performing the same act in similar circumstances;

(15) that the standard of reasonable knowledge, care and skill recommended above apply also in emergency situations, taking in consideration the particular circumstances of the case;

(16) that the acceptable minimum standard for the unqualified person in the administration of treatment be that of the reasonable, ordinary person and not that of the qualified person;

(17) that where a person holds himself out as having certain qualifications and where the public or the individual treated rely on these qualifications, that person be judged according to the standard of the qualified person he represented himself to be;

(18) that the substance of the present provisions of the *Criminal Code* concerning duties tending toward the preservation of life be retained;

(19) that these provisions be extended to apply also where there is a danger of permanent injury to a person's health;

(20) that the *Criminal Code* make separate provisions for the general duty of reasonable knowledge, care and skill in the performance of dangerous acts and for the duty of reasonable knowledge, care and skill, in the administration of treatment by qualified professionals;

(21) that the duty of reasonable knowledge, care and skill apply upon the undertaking of the administration of treatment;

(22) that an exception to the duty to undertake or to continue a treatment be recognized when necessary resources are not available;

(23) that the *Criminal Code* recognize the general duty to render assistance to an individual in danger, where the life or health of that person is seriously threatened and the circumstances are such that the person is aware of the emergency and can provide immediate assistance without undue hardship to himself.

2. Implementation of Reform: Models for the Criminal Code

Although the implementation of the above recommendations does not rest on statutory reform alone, the Commission is of the opinion that some legislated reforms are necessary. Given the desire for precision and a degree of certainty in the Code, what legislative framework can best bring about the desired change? There are two possibilities:

A. The Defence Model: Present Criminal Code Clarified

As outlined in Part II, the traditional method of protecting doctors in the administration of treatment has been through the creation of specific defences which counterbalance the general inclusiveness of the administration of treatment amongst the offences against the person. With changes in the scope of the present defences so that the ultimate legality of the proper administration of treatment will be certain, this method could indeed resolve many of the problems raised in this Working Paper. It has the advantage of avoiding the proliferation of specific offences in the Code, while maintaining the characterization of treatment as an application of force upon the body of another. The special status of treatment could be recognized.

However, this method does not resolve all problems associated with tying the administration of treatment into the more general offences. The mental requirement and causation elements of the general offences against the person are needlessly complicated when attempts are made to equate every day conduct of high social utility with sporadic violence against the person. Furthermore, the goal of any legislative change should also be to relieve the anxiety and stress of potential criminal liability for those who carry on professional activities consistent with societal interest in the preservation of life and health. The creation of a specific offence for the wrongful administration of treatment may be a more solid mechanism for achieving this goal. However, unless there is included a specific exception,

there is no guarantee that the offences against the person might not be invoked in serious cases.

B. The Offence Model: The Preferred Solution

The second alternative is to create a specific offence for wrongful administration of treatment. This would practically take treatment by qualified personnel out of the operative effect of the general offences against the person, in a way somewhat similar to the present mechanism for abortion. However, it may be desirable to exempt treatment specifically as done in West Germany. A sub-part could thus be created within the *Criminal Code*'s Offences Against the Person, to deal specifically with the administration of treatment. It would include the present abortion provisions.

A number of reasons operate to make this model the favoured one. First, it follows the very simple principle that different cases should be treated differently and like cases the same. The *Criminal Code* has traditionally created specific offences for the regular performance of similarly dangerous acts such as the operation of motor vehicles and maritime vessels. The Code has already leaned this way in treatment through the creation of specific duties, the breach of which is a general offence. The clarification of an offence for wrongful administration of treatment would serve to equate this activity with similar conduct regularly performed in society, and rarely criminal in terms of culpability. Second, the differentiation of treatment in this way more realistically reflects the value of treatment to society and the basic trust individuals place in the competence of the practising health professions. Third, the separation of treatment is the only sure method of minimizing the confusion created by its inclusion in the more general offences. A new section could codify the existing and desirable law with regard to treatment, thus creating an exclusivity, as in the abortion provisions. Fourth, the inclusion of all the criteria for the lawful administration of treatment as elements of an offence would desirably place a heavier burden of proof on the Crown. Fifth, it would no longer be necessary to raise a defence based on the

character of the act itself, thus implying more forcefully the basic legality of treatment.

To conclude, the Commission favours the drafting of a new offence for the wrongful administration of treatment. Part VI of the *Criminal Code* would have a new sub-part entitled "Treatment" which would include abortion and other provisions pertaining to the medical environment. The substance of the new offence would be based on the recommendations discussed above. The basic content of the new provision and the necessary amendments to the Code are indicated in the following draft legislation.

3. Draft Legislation

This outline of legislation is only tentative and put forth to focus discussion. It does not represent the final view of the Commission, nor the co-ordination result of all proposed legislation emanating from the Protection of Life Project. A more complete and comprehensive draft will follow in the Report to Parliament on these issues.

Moreover, the Commisson does not at present make specific recommendations as to penalties and sentences for the same reasons.

DRAFT LEGISLATION

EXPLANATORY NOTES

Section 45 — Surgical Operations

Deleted from Code

This section is not sufficiently broad to cover all treatment. Moreover it is ambiguous as to scope. The justification based on those who perform operations as persons in authority is unwarranted. The more general defences provide adequate protection.

Duties Tending to Preservation of Life and Health

Section 197 — Duty of Persons to Provide Necessaries

Unchanged

This section creates an obligation upon parents, spouses, and persons in charge of helpless individuals to provide the necessaries to life and health. It is fully consistent with the policy of this Working Paper.

Section 198 — Duty of Persons Undertaking Acts Dangerous to Life or Health

Every one who does any act that may endanger the life of another person or is likely to cause the health of another person to be injured permanently, is under a legal duty to have and to use reasonable knowledge, skill, and care in so doing.

The exclusion of the reference to administration of surgical and medical treatment from this section, does not negate the duty of reasonable knowledge, skill and care upon qualified or unqualified person administering treatment.

The duty for the qualified person appears in the new section 251.1. Others fall within this section's general duty. The exclusion of the present exemption for cases of necessity affirms the Commission view that reasonableness should also apply in these cases, with recognition of a flexible standard that is appreciative of the circumstances. "Lawful" acts referred to in section 198, is deleted to clarify that the duty applies to all acts. Danger to health is added to be consistent with section 197 and to re-affirm the Code's purpose of protecting both life and health.

Section 199 — Duty of Persons Undertaking Acts

Every one who undertakes to do an act is under a legal duty to do it, if an omission to do so is or may be dangerous to life or causes or is likely to cause the health of another person to be injured permanently, unless there is lawful excuse for not doing the act.

The new proposed draft, broadens the duty to include protection of health. The addition of lawful excuse and justification operates to free someone from a duty to complete when the reason for non-completion is due to a lack of resources or other cause beyond the control of the person undertaking to do the act.

Section 199.1 — Duty of Persons in an Emergency

Every one is under a legal duty to render assistance to another in an emergency, when

This new section imposes a duty to give assistance in an emergency situation.

life or health is seriously threatened and the circumstances are such that there exists knowledge of the emergency and that the assistance can be immediately provided without undue hardship, justification or lawful excuse.

Treatment

Subsection 251.1(1) — Treatment not Harm

The administration of treatment by a qualified health person does not constitute bodily harm or physical injury within the meaning of this act, provided it is reasonable in all the circumstances of the case and consistent with the provisions of this section and of section 251.2. It attempts to set out the standard of duty developed by the case law and leaves the appreciation of the particular circumstances of the case to the trier of fact.

This frees the administration of treatment from the operation of the moral general offences against the person in most cases. It reflects the view of the Commission that treatment should be differentiated from other acts constituting the application of force on the body of an individual.

Subsection 251.1(2) — Qualified Health Person

For the purposes of this section, a qualified health person includes every one who is entitled to practice any of the healing sciences by provincial law.

Subsection (2) distinguishes the qualified from the unqualified, on the basis of provincial law.

Subsection 251.2(1) — Wrongful Treatment

A qualified health person wrongfully administers treatment to another when

(*a*) treatment is administered without that person's consent or contrary to that person's refusal, or

(*b*) treatment is administered without the knowledge, skill and care which would normally be used by another competent similarly qualified person, or

(*c*) the administration of treatment is unreasonable in the circumstances.

This subsection incorporates the elements of reasonableness as in present section 45. The addition of consent and refusal of treatment serves as clarification of present law. The addition of the competency standard makes clear that it is a professional standard.

Section 251.2(2) — Exceptions

Treatment may be administered without a person's consent when, in the case of emergency that person is incapable of expressing consent, when that person is adjudged incompetent or there is another exception recognized by law.

The purpose of this section is to facilitate treatment of those unable to consent, to express their consent, and in special cases recognized by law.

Subsection 251.2(3) — Incompetency

A person is incompetent to consent to treatment if a finding to that effect has been made by a superior, district or county court.

This assures to incompetents full protection of the person and assures the principle of valid consent as a prerequisite to treatment.

Subsection 251.2(4) — Non-therapeutic Interventions on Incompetents

All decisions regarding non-therapeutic interventions upon persons found to be incompetent under subsection (3), shall be made by a provincial board appointed or designated by the Minister of Health.

This subsection establishes a board to make decisions for incompetents when there is to be no therapeutic benefit from intervention. This section is not complete in itself but must be read in conjunction with the definitions in the present section 251 (abortion). The Commission, however, expresses no views or comments on the present section 251.

Endnotes

1. Paris, John J. "Compulsory Medical Treatment and Religious Freedom: Whose Law Shall Prevail?" 10 *University of San Fransisco Law Review* 1, (Summer 1975), at p. 28.

2. Gibbs, Richard "$7-million Awarded in Childbirth Death" 5(9) *Legal Aspects of Medical Practice* 55 (1977); also, Holdsworth, Sir William, *A History of English Law*, 306 (4th ed. 1966) for recognition of something as a crime, when it is realized that the tort remedy is inadequate.

3. Law Reform Commission of Canada, *Our Criminal Law* 16, 33 (1976).

4. Most offences and duties provide specific punishment for violation. Note, however, that *Criminal Code*, R.S.C. 1970, c. C-34, s. 197 as amended (hereinafter cited as "*Criminal Code*") does not include a specific punishment for violation. In such cases, s. 115(1) of the Code provides:

   > Every one who, without lawful excuse, contravenes an Act of the Parliament of Canada by wilfully doing anything that it forbids or by wilfully omitting to do anything that it requires to be done is, unless some penalty or punishment is expressly provided by law, guilty of an indictable offence and is liable to imprisonment for two years.

5. House of Commons, Twenty-fourth Parliament *Special Committee on Human Rights and Fundamental Freedoms* (1960), 415.

6. Law Reform Commission of Canada, *Limits of Criminal Law* Ottawa: Canada 1975, 40.

7. Blackstone, *Commentaries*, Book I, 130 (1966).

8. *Canadian Bill of Rights*, S.C. 1960, c. 44, s. 1(*a*).

9. *Universal Declaration of Human Rights* (1948) Article 25, para. 1:

   > Every one has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.

10. Callahan, Daniel "The WHO definition of 'health' " *The Hastings Center Studies* 1:3, 1973, 77. This article forms the basis of the WHO definition criticism in this paper.

11. *Ibid.*, at 81.

12. *Morgentaler v. R.* [1976] 1 S.C.R. 616 at 671.

13. *R. v. Bourne*, [1939] 1 K.B. 687, [1938] 3 All E.R. 615; *R. v. Newton and Stungo* [1958] Crim. L. R. 469.

14. Dickens, Bernard M., *Abortion and the Law*, (1966); Williams, Glanville L., *The Sanctity of Life and the Criminal Law*, (1958).

15. Government of Canada, *Report of the Committee on the Operation of the Abortion Law* 207, (1977).

16. *Morgentaler v. R.*, *supra*, note 12 at 676 per Dickson, J.

17. Callahan, "The WHO definition of 'health' ", *supra*, note 10 at 87. This view is an expansion of Callahan who, along with Veatch "The medical model: its nature and problems" *The Hastings Center Studies* 1:3 (1973), 59 would confine health to "physical health". Wider notions of health are preferred by Steinfels, Peter "The Concept of Health: An Introduction" *The Hastings Center Studies* 1:3 (1973), 3 provided that health and medicine are not inextricably intertwined. Williams, *The Sanctity of Life and the Criminal Law*, *supra*, note 14 and Dickens, *Abortion and the Law*, *supra*, note 14 both favour absolute physician discretion in abortion.

18. *Stroud's Judicial Dictionary*, 4th ed., Vol. 4, 2098; *Black's Law Dictionary*, 4th ed., 1348.

19. *Criminal Code*, section 25(1):

> Every one who is required or authorized by law to do anything in the administration or enforcement of the law
>
> (*a*) as a private person,
>
> (*b*) as a peace officer or public officer,
>
> (*c*) in aid of a peace officer or public officer, or
>
> (*d*) by virtue of his office
>
> is, if he acts on reasonable and probable grounds, justified in doing what he is required or authorized to do and in using as much force as is necessary for that purpose.

20. *Criminal Code*, subsection 34(1):

> Every one who is unlawfully assaulted without having provoked the assault is justified in repelling force by force if the force he uses is not intended to cause death or grievous bodily harm and is no more than is necessary to enable him to defend himself.

Criminal Code, subsection 38(1):

> Every one who is in peaceable possession of movable property, and every one lawfully assisting him, is justified
>
> (*a*) in preventing a trespasser from taking it, or
>
> (*b*) in taking it from the trespasser who has taken it,
>
> if he does not strike or cause bodily harm to the trespasser.

21. *Criminal Code*, sections 43, 44 and 45 (see notes 22, 23, 24 below). "Protection of Persons in Authority" is the title given to these sections which are contained within Part I, the general part of the Code.

22. *Criminal Code*, section 43:

> Every schoolteacher, parent, or person standing in the place of a parent is justified in using force by way of correction toward a pupil or child, as the case may be, who is under his care, if the force does not exceed what is reasonable under the circumstances.

23. *Criminal Code*, section 44:

> The master or officer in command of a vessel on a voyage is justified in using as much force as he believes, on reasonable and probable grounds, is necessary for the purpose of maintaining good order and discipline on the vessel.

24. *Criminal Code*, section 45:

> Every one is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if
>
> (*a*) the operation is performed with reasonable care and skill, and
>
> (*b*) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case.

25. Turner, J. W. Cecil, *Kenny's Outlines of Criminal Law*, 19 (19th ed., 1966); *R. v. Senior* [1899] 1 Q.B. 283; *Aldworth v. Stewart* (1966) 4 F. & F. 957; *Hook v. Cunard Steamship Co.* [1953] 1 W.L.R. 682.

26. Turner, *Kenny's Outlines of Criminal Law*, *ibid.*. This is still the case in the administration of treatment in the *Criminal Code*, s. 198 (*St. Germain v. R.* (1976) Que. C.A. 185).

27. Jolowicz, J. A. *Winfield and Jolowicz on Tort*, 621, (9th ed. 1971).

28. *Black's Law Dictionary*, *supra*, note 18 at 168; Kaufman, Fred. *The Admissibility of Confessions*, 54, (2nd ed. 1974).

29. *R. v. Anderson* (1914) 22 C.C.C. 455 at 460; Kaufman, *The Admissibility of Confessions*, *ibid.* at 57-63.

30. *Marshall v. Curry* [1933] 3 D.L.R. 260 at 274, 60 C.C.C. 136, per Chisholm C.J.

31. Szasz, T. S. and Hollender, M. H. "A Contribution to the Philosophy of Medicine" *Archives of Internal Medicine* 97, (1956).

32. *R. v. Williamson* (1807) 3 Car. & P. 635, 172 E.R. 579.

33. American Law Institute, *Model Penal Code* 1962, section 3.08.

34. Young, J. Talbot Jr., "Separation of Responsibility in the Operating Room: The Borrowed Servant, the Captain of the Ship, and the Scope of Surgeons' Vicarious Liability" 49 *Notre Dame Lawyer* 933 (1974).

35. Bloom, Samuel W. and Wilson, Robert N. "Patient-Practitioner Relationships" in Freeman, Levine, Reeder (eds.) *Handbook of Medical Sociology* 315 (2nd ed. 1972); Mechanic, David *Medical Sociology* 158 (1968).

36. Stephen, *Digest of the Criminal Law*, 7th ed. 1926, section 294; *R. v. Clarence* (1888) 22 Q.B.D. 23.

37. Historically, offences against the person other than homicide were not crimes. This changed, however, in medieval times, as a maiming or the injury of another so rendering him less able to fight or defend himself constituted the crime of mayhem. In modern times, the unlawful threat or application of force to another person is also an assault or battery respectively in law. The common law broadly describes these crimes as the threat of or the infliction of violence upon a person and holds all interference with the person in even the slightest manner to be a crime unless there is legal justification. Stephen, Sir James Fitzjames, *A History of the Criminal Law of England*, Vol. III, 108 (1883); Dworkin, "The Law Relating to Organ Transplantation in England", 33(4) *Modern Law Review*, 353, (1970); Smith and Hogan, *Criminal Law*, 281 (3rd ed. 1973); Turner, J. W. C., *Russell on Crime*, Vol. I, 655, (12th ed. 1964).

38. Note that although justification implies vindication, it is still classified as a form of defence.

39. Section 45 of the *Criminal Code* was amended (1953-54, c. 51, s. 45) to clarify that the performance of the operation must be reasonable "having regard to the state *of health* of the person at the time . . ." [emphasis added] (See the earlier wording below, note 40).

40. Draft Code 1880, s. 68:

> Every one is protected from criminal responsibility for performing with reasonable care and skill any surgical operation upon any person for his benefit: provided that performing the operation was reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

41. Stephen, *Digest of the Criminal Law*, *supra*, note 36, section 289; Turner, *Russell on Crime*, *supra*, note 37 at 680.

42. *R. v. Donovan* [1934] 2 K.B. 498, 509; Dworkin "The Law Relating to Organ Transplantation in England", *supra*, note 37; Turner, *Russell on Crime*, *supra*, note 37 at 678.

43. This point is alluded to by Starkman, Bernard "Preliminary Study on Law and the Control of Life" unpublished paper prepared for the Law Reform Commission of Canada, (August 1974). See also his, "A Defence to Criminal Responsibility for Performing Surgical Operations" in *The Dying Human* (1979), ed. A. de Vries and A. Carmi.

44. *Criminal Code*, 1892 (55-56 Vict., c. 29), section 212.

45. Taschereau, Henri Elzéar *The Criminal Law Consolidation and Amendment Acts of 1869*, 30-33 Vict. (1874).

46. Dworkin, "The Law Relating to Organ Transplantation in England", *supra*, note 37 at 356-357. Note that the fourth criteria here is slightly different from Dworkin in order to clarify that the person does not need to have the appropriate skills in the sense of qualification, provided the act is performed with appropriate skill for the nature of the procedure.

47. *Final Report of the National Commission on Reform of Federal Criminal Laws*, (1971) (U.S.) section 1619.

48. *Ibid.*, section 605(d).

49. Stefani, G. *Quelques Aspects de l'Autonomie du Droit Pénal* 202, (1956); Hughes, "Two Views on Consent in the Criminal Law", 26(3) *Modern Law Review*, 242, (1963).

50. Stefani, G. *Quelques Aspects de l'Autonomie du Droit Pénal*, *ibid.*, at 203.

51. *The Austrian Penal Act*, sections 356, 357, 358 (1966).

52. *The German Draft Penal Code* 1962, section 161 (1966):

> Operations and other treatments which according to medical knowledge and experience and according to the principles of a scrupulous physician are necessary and are performed in order to prevent, diagnose, cure or alleviate illness, suffering, body damage, physical complaints and psychic disturbance are not punishable as physical harm.

53. *Ibid.*, section 162.

54. *Alternative Draft of a Penal Code for the Federal Republic of Germany*, sections 112, 123 (1977).

55. *Criminal Code*, section 244:

> A person commits an assault when
> (*a*) without the consent of another person or with consent where it is obtained by fraud, he applies force intentionally to the person of the other, directly or indirectly;
> (*b*) he attempts or threatens, by an act or gesture, to apply force to the person of the other, if he has or causes the other to believe upon reasonable grounds that he has ability to effect his purpose;

Criminal Code, section 245:

> (1) Every one who commits a common assault is guilty of an offence punishable on summary conviction.
> (2) Every one who unlawfully causes bodily harm to any person or commits an assault that causes bodily harm to any person
> (*a*) is guilty of an indictable offence and is liable to imprisonment for five years; or
> (*b*) is guilty of an offence punishable on summary conviction.

56. *R. v. George* [1960] S.C.R. 871 at 890, 34 C.R. 1, 128 C.C.C. 289; *R. v. Alec* (1973) 25 C.R.N.S. 327 at 332, [1974] 1 W.W.R. 645, 15 C.C.C. (2d) 164 (B.C.C.A.). Note further that there may also be a psychological assault if someone encourages somebody else to do something dangerous and thereby indirectly causing harm.

57. The fact of requisite intent is assumed in the literature. See, for example, O'Connor, D. "Transplant Surgery and the Criminal Law" 3(4) *Aust. and N.Z. Journal of Criminology*, 223 (Dec. 1970), 223; Skegg, P. D. G. "Medical Procedures and the Crime of Battery" (1974) *Criminal Law Review*, 693.

58. Smith and Hogan *Criminal Law*, *supra*, note 37 at 304; *Harley* (1830) 4 C & P 369; *Dale* (1852) 6 Cox C.C. 14.

59. *Laporte v. Laganière* (1972) 18 C.R.N.S. 357 at 361 (Que. Q.B.).

60. Razovsky, Lorne Elkin "The Laboratory Technologist and the Law" *Canadian Journal of Medical Technology 32* (June 1970), 95.

61. Dewhurst, W. G. "Drug Dependence: An Analysis" 9 *Alberta Law Review*, 215, (1971), at 220.

62. *Laporte v. Laganière*, *supra*, note 59 at 365.

63. Turner, *Kenny's Outlines of Criminal Law*, *supra*, note 25 at 206.

64. *Agnew v. Jobson* (1877) 13 Cox C.C. 625.

65. See, for example, *Public Health Act*, R.S.M. 1970, c. P210, section 44; *The Mental Health Act*, R.S.O. 1970, c. 269 as amended by S.O. 1978, c. 50, section 31a; *Heroin Treatment Act*, S.B.C. 1978, no. 18.

66. *R. v. Meredith* (1838) 8 Car. & P. 589, 173 E.R. 630; *R. v. Wollaston* (1872) 12 Cox C.C. 180; *R. v. Setrum* (1976) 32 C.C.C. (2d) 110.

67. *R. v. Setrum*, *ibid.*; *R. v. Abraham* (1974) 30 C.C.C. (2d) 332, 26 C.R.N.S. 390; *R. v. Dix* (1972) 10 C.C.C. (2d) 324; *R. v. MacTavish* (1972) 8 C.C.C. (2d) 206, 20 C.R.N.S. 235, 4 N.B.R. (2d) 876.

68. *R. v. Dix*, *ibid.*, at 325-326; see also *R. v. MacTavish*, *ibid.*; *R. v. Abraham*, *ibid.*

69. *Marshall v. Curry*, *supra*, note 30 at 264; *Mulloy v. Hop Sang* [1935] 1 W.W.R. 714 at 715.

70. *Criminal Code*, section 244, *supra*, note 55; *R. v. Lock* (1872) L.R. 2 C.C. 10, 12 Cox C.C. 244.

71. *Bolduc v. Bird* (1967) 63 D.L.R. (2d) 82 (S.C.C.).

72. *R. v. William Case* (1850) 4 Cox C.C. 220.

73. Smith and Hogan *Criminal Law*, *supra*, note 37 at 287; *Nichol* (1807) Russ. & Ry. 130.

74. Turner *Russell on Crime, supra*, note 37 at 680; Williams, Glanville, *Criminal Law*, 867, (2nd ed. 1961).

75. *Turner*, *ibid.*

76. *In re Caughey* [1976] 1 Ch. 521 at 528.

77. *Papadimitropoulos v. The Queen* (1957) 98 C.L.R. 249 at 261.

78. *Bolduc v. Bird*, *supra*, note 71 at 83.

79. *Burrell v. Harmer* (1966) 116 New L.J. 1658, [1967] Crim. L.R. 169.

80. Some age provisions for children in the *Criminal Code* are as follows: criminal responsibility at 7 (s. 12) and 7-14 (s. 13); effective consent to sexual assault at 14 (s. 140); provision of necessaries to 16 (s. 197); corruption of children under 18 (s. 168). Note that the Law Reform

Commission of Canada has recommended changes to some of these sections in *Report on Sexual Offences*, 1978.

81. *R. v. Donovan*, *supra*, note 42 at 507.

82. *Ibid.* at 509. There are many gradations between a slight tap and a severe blow and *Donovan* said that whether bodily harm was likely was a question for the jury. See Skegg "Medical Procedures and the Crime of Battery", *supra*, note 57, at 695; also *R. v. Maloney*, (1976) 28 C.C.C. (2d) 323.

83. *R. v. Donovan*, *ibid.*

84. *R. v. Coney* (1882) 8 Q.B.D. 534, per Steven, J. at 549.

85. *Bravery v. Bravery* [1954] 1 W.L.R. 1169 at 1175, [1954] 3 All E.R. 59.

86. *Ibid.* per Denning, L. J. at 1180. For a comment on the two social policy approaches, Skegg, P. D. G. "Medical Procedures and the Crime of Battery" *supra*, note 57 at 700.

87. Skegg, "Medical Procedures and the Crime of Battery" *supra*, note 57 at 697.

88. See the various provincial Human Tissue Gift Acts on transplantation. Transsexual surgery is facilitated in New Brunswick and Quebec by birth registry change.

89. For cases applying or considering *R. v. Coney* but notably for other purposes, see *R. v. Halmo* [1941] O.R. 99; *R. v. Hoggan* 53 W.W.R. 641; *R. v. Byrne* 63 W.W.R. 385; *R. v. Curran* [1978] 1 W.W.R. 255. For cases applying or considering *R. v. Donovan* but also for other purposes, see *R. v. Cullen* [1949] O.R. 10; *R. v. Morrill* [1954] O.W.N. 425; *R. v. Bursey* 27 C.R. 167; *Carrier v. R.* 23 C.R.N.S. 243. For Canadian commentary against the rule, see Lagarde, I. *Droit Pénal Canadien*, Wilson & Lafleur Ltée: Montreal 1974, 655; Tremeear's Canadian *Criminal Code*, 6th Ed., Part VI at 372; Hechter, William "The Criminal Law and Violence in Sports" 19 *Criminal Law Quarterly* 425 (1976-77), at 430; see also the cases referred to in *supra*, note 67; Hughes, G. J. "Criminal Law — Defence of Consent — Test to be Applied" 33 *Canadian Bar Review* 88 (1955).

90. Martin's *Criminal Code* 1955, section 230, notes.

91. *Criminal Code*, paragraph 197(1)(*a*):

> Every one is under a legal duty
> (*a*) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;

92. *Criminal Code*, paragraph 197(1)(*b*):

> Every one is under a legal duty
> (*b*) as a married person, to provide necessaries of life to his spouse;

93. *Criminal Code*, paragraph 197(1)(*c*):

Every one is under a legal duty

(*c*) to provide necessaries of life to a person under his charge if that person

(i) is unable, by reason of detention, age, illness, insanity or other cause, to withdraw himself from that charge, and

(ii) is unable to provide himself with necessaries of life.

94. Tremeear's *Criminal Code*, *supra*, note 89, notes on subsection 197(1).

95. *Criminal Code*, paragraph 197(2)(*a*):

Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies upon him, to perform that duty, if

(*a*) with respect to a duty imposed by paragraph (1)(*a*) or (*b*),

(i) the person to whom the duty is owed is in destitute or necessitous circumstances, or

(ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently;

96. *Criminal Code*, paragraph 197(2)(*b*):

Every one commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse, the proof of which lies upon him, to perform that duty, if

(*b*) with respect to a duty imposed by paragraph (1)(*c*), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

97. *R. v. Steele* (1952) 102 C.C.C. 273 (Ont. C.A.).

98. *R. v. Smith* (1865) Le & Ca. 607, 34 L.J.M.C. 153, 10 Cox C.C. 82, 169 E.R. 1533 (C.A.); *R. v. Chattaway* (1922) 17 Cr. App. R. 7; *R. v. Nicholls* (1875) 13 Cox C.C. 75; *R. v. Brown* (1893) 1 Terr. L.R. 475.

99. *Hôpital Notre-Dame v. Patry* (1972) C.A. 579.

100. *R. v. Chattaway*, *supra*, note 98.

101. *R. v. Senior* [1899] 1 Q.B. 283, 68 L.J.Q.B. 175, 19 Cox C.C. 219; *R. v. Brooks* (1902) 9 B.C.R. 13, 5 C.C.C. 372 (C.A.); *R. v. Lewis* (1903) 6 O.L.R. 132, 7 C.C.C. 261 (C.A.).

102. *R. v. Brooks*, *ibid.*; *R. v. Lewis*, *ibid.*

103. *R. v. Sidney* (1912) 2 W.W.R. 761, 21 W.L.R. 853, 5 Sask. L.R. 392, 20 C.C.C. 376, 5 D.L.R. 256 (C.A.).

104. *R. v. Morley* (1882) 8 Q.B.D. 571, 51 L.J.M.C. 85, 15 Cox C.C. 35.

105. *R. v. Nasmith* (1877) 42 U.C.Q.B. 242; *R. v. Yuman* (1910) 22 D.L.R. 500, 17 C.C.C. 474; *R. v. Bunting* (1926) 58 O.L.R. 373, 45 C.C.C. 135; *R. v. Joudrey* 64 C.C.C. 130, [1935] 3 D.L.R. 754.

106. *R. v. Smith*, *supra*, note 98.

107. *R. v. Brooks*, *supra*, note 101; *R. v. Lewis*, *supra*, note 101; *R. v. Senior*, *supra*, note 101; *R. v. Elder* (1925) 44 C.C.C. 75; *R. v. Downes* (1875) 1 Q.B.D. 25; *R. v. Morley*, *supra*, note 104; *R. v. Cook* (1898) 62 J.P. 712.

108. *Boucher v. R.* [1951] S.C.R. 265, 11 C.R. 85, 99 C.C.C. 1.

109. *Birks and Sons v. City of Montreal* [1955] S.C.R. 799, 113 C.C.C. 135.

110. Lagarde, *supra*, note 89 at 459.

111. *Criminal Code*, section 198:

> Every one who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and to use reasonable knowledge, skill and care in so doing.

Criminal Code, section 199:

> Every one who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.

112. *Criminal Code*, subsection 115(1), *supra*, note 4.

113. *Criminal Code*, section 198.

114. *R. v. Homeberg* (1921) 35 C.C.C. 240 at 246.

115. The origins of the non-discrimination actually date to a controversy between Blackstone and Hale on the one hand, and Coke on the other. *Blackstone's Commentaries*, Book 4, c. 14 (1966) agree with Hale, 1 *Hale's Pleas of the Crown* 429 as follows:

> If a physician gives a person a potion without any intent of doing him any bodily hurt, but with an intent to cure or prevent a disease, and, contrary to the expectation of the physician, it kills him, this is no homicide; and the like of a chirurgeon. And I hold their opinion to be erroneous that think, if he be no licensed Chirurgeon or physician that occasioneth this mischance, that then it is a felony, for physic and salves were before licensed physicians and chirurgeons, and therefore if they be not licensed, according to the statute of the 3H.VIII, c. 11, or 14H.VIII, c. 5, they are subject to the penalties in the statutes; but God forbid that any mischance of this kind should make any person no licensed guilty of murder or manslaughter.

Coke, however, had said in 4 *Institutions* 251:

> If one that is of the mystery of a physician take a man in cure, and giveth him such physic as within three days he die thereof, without any felonious intent, and against his will, it is no homicide; but Britton saith, that if one that is not of the mystery of a physician or chirurgeon take upon him the cure of a man, and he dieth of the potion or medicine, this is, (saith he), covert felony.

> The basic non-discriminatory statement of Hale was applied in *R. v. Van Butchell*, (1829) 3 Car. & P. 630, 172 E.R. 576, to the effect

that failure of an operation performed properly should not amount to manslaughter. The additional questions arising from Hale and Coke of the defence of good intentions alone and degrees of competence develop through another line of cases.

116. *R. v. Homeberg*, *supra*, note 114 at 246.

117. *R. v. Burnshine* (1974) 44 D.L.R. (3d) 584 (S.C.C.). Martland J. in referring to the *Prison and Reformatories Act*, R.S.C. 1970, c. P-21, section 150 and the *Canadian Bill of Rights*, R.S.C. 1970, App. III, section 1(b) said at 592:

> It is quite clear that, in 1960, when the Bill of Rights was enacted, the concept of 'equality before the law' did not and could not include the right of each individual to insist that no statute could be enacted which did not have application to everyone and in all areas of Canada.

118. *Ibid.*

119. The ancient principle of strict liability is founded in Coke, *supra*, note 115, and is expressed in *R. v. Spiller* (1832) 5 Car. & P. 333, 172 E.R. 999; *R. v. Burdee* (1916) 12 Cr. App. R. 153, 25 Cox C.C. 598, 115 L.T. 904. For a recent application, see *R. v. Rogers* (1968) 65 W.W.R. 193.

120. *R. v. Van Butchell*, *supra*, note 115; Hale, *Hale's Pleas of the Crown*, *supra*, note 115.

121. Turner, *Kenny's Outlines of the Criminal Law*, *supra*, note 25 at 19. This notion is based on the fundamental democratic principles of the security of the person and right to self-determination. The principle was re-enunciated in July, 1978 when an American court upheld the refusal of a man to submit to surgery to save the life of his cousin (*McFall v. Shrimp*, *Ottawa Citizen*, Thursday, July 27, 1978, page 70).

122. Camps, Francis E. (ed.) *Gradwohl's Legal Medicine*, 421, (3rd ed., 1976); Canadian Medical Association, *Code of Ethics*, June 1975, section 12, ". . . shall, except in an emergency, have the right to refuse to accept a patient."

123. *Code of Ethics*, *ibid.*; *New Biloxi Hospital v. Frazier* (1962) 146 So. 2d 882; *Reeves v. North Broward Hospital* (1966) 191 So. 2d 307; *Vancouver General Hospital v. Fraser* [1952] 2 S.C.R. 36; *St. Germain v. R.*, *supra*, note 26; *Pratt v. Davis* 224 All 300; *Marshall v. Curry*, *supra*, note 30; Wright and Linden, *Canadian Tort Law* (6th ed. 1975); Fleming, John G. *The Law of Torts* (1971).

124. *St. Germain v. R.*, *supra*, note 26.

125. Camps, *Gradwohl's Legal Medicine*, *supra*, note 122; Holder, Angela Roddey, *Medical Malpractice Law*, 3, (1975); Horan, Dennis J., "Euthanasia, Medical Treatment and the Mongoloid Child: Death as a Treatment of Choice?" 27 *Baylor Law Review*, 76 (1975), at 80.

126. *Cassidy v. Minister of Health* [1951] 1 All E.R. 574; *Vancouver General Hospital v. Fraser*, *supra*, note 123; *Darling v. Charleston Community Memorial Hospital* (1965) 33 Ill. 2d 326, 211 N.E. 2d 253 (certiorari denied 383 U.S. 946).

127. *Cassidy v. Minister of Health*, *ibid.*; but see also *R. v. Giardine* (1939) 71 C.C.C. 295 where it was held that a doctor could rely on the assumption that orders given to a nurse would be carried out.

128. For a general theory on the administration of treatment, see Beresford, H. Richard, "Judicial Review of Medical Treatment Programs" 12 *California Western Law Review*, 332, (1976), at 347.

129. *R. v. Homeberg*, *supra*, note 114, at 245.

130. There is the likelihood, however, of standard of care being established by the admissibility of rules and regulations of the province, city, and hospital as well as standards of accreditation. See, for example, developments in the United States, *Darling v. Charleston Community Memorial Hospital*, *supra*, note 126; Rupe, A. and Steiger, Robert "Hospitals' Expanding Role and Responsibility in Health Care Delivery" 14 *Washburn Law Journal*, 580, (1975), at 582.

131. R. v. Homeberg, *supra*, note 114 at 245.

132. *Ibid.* at 214; *Wilson v. Swanson* [1956] S.C.R. 804, 5 D.L.R. (2d) 113 per Rand J. at 119-120.

133. *R. v. Giardine*, *supra*, note 127 at 300; *R. v. Rogers*, *supra*, note 119. *R. v. Giardine* said one is "criminally liable if [he] falls below the standard of skill that the least qualified doctor should have." But, *R. v. Rogers* referred to the knowledge and skill of the "ordinary physician".

134. *Chasney v. Anderson* [1949] 4 D.L.R. 71 (Man. C.A.); [1950] 4 D.L.R. 223 (S.C.C. Affirmed); Vandervort, Lucinda, "Legal Aspects of the Medical Treatment of Penitentiary Inmates" (1977) *Queen's Law Journal*, 368, at 387.

135. *R. v. Homeberg*, *supra*, note 114 at 246.

136. Coke, *supra*, note 115.

137. *R. v. Rogers*, *supra*, note 119 at 215, quoting *Commonwealth v. Pierce* (1884) 138 Mass. 165 as follows:

> Common experience is necessary to the man of ordinary prudence, and a man who assumes to act as the defendant did must have it at his peril . . . we cannot recognize a privilege to do acts manifestly endangering human life on the grounds of good intentions alone.
>
> *R. v. Webb* (1834) 1 M. & Rob. 405, 174 E.R. 140 applied this concept when proper medical assistance could be obtained.

138. See the argument advanced in *R. v. Webb*, *ibid.*, as opposed to *R. v. Rogers*, *ibid.*

139. The position in private law with regard to all licensure has been suggested by Fleming, *The Law of Torts*, supra, note 123 at 128, although the Canadian position is not known. The criminal law position is guided by the Supreme Court of Canada in *R. v. Wray* [1971] S.C.R. 272 wherein evidence that may operate unfairly for the accused because of its gravely prejudicial effect will be excluded if its probative force in relation to the main issue before the court is trifling. Although licensure

would seem to fall within this exclusionary rule, the point is undecided in Canadian law.

140. *McCaffrey v. Hague* [1949] 2 W.W.R. 539, [1949] 4 D.L.R. 291; *Wilson v. Swanson*, *supra*, note 132; *The Canadian Abridgment*, Vol. 25, (2nd ed.); Jolowicz, *Winfield and Jolowicz on Tort*, *supra*, note 27 at 61.

141. *Criminal Code*, section 199, *supra*, note 111.

142. *R. v. Instan* 1893 1 Q.B.D. 450, 17 Cox C.C. 602; *Criminal Code*, S.C. 1892 (55-56 Vict. c. 29), section 214. Note, however, that the *Criminal Code* limits the duty to an initial undertaking, therefore ruling out the imposition of common law duties.

143. Turner, *Russell on Crime*, *supra*, note 37 at 402; Smith and Hogan, *Criminal Law*, *supra*, note 37 at 40.

144. Kouri, Robert P., "Blood Transfusions, Jehovah's Witness and the Rule of Inviolability of the Body", 5 R.D.U.S., 156, (1974), at 173; Waltz, John R. and Inbau, Fred E., *Medical Jurisprudence*, 143 (1971); Sanders, David and Dukeminier, Jesse, "Medical Advance and Legal Lag: Haehodialysis and Kidney Transplantation", 15 *University of California Law Review*, 357, (1967-68), at 382; Levin, Col. Maurice, "The Abandoned Patient" (1965) *Insurance Law Journal* 275.

145. Walts and Inbau, *Medical Jurisprudence*, *ibid.*

146. Kouri, "Blood Transfusions, Jehovah's Witnesses and the Rule of Inviolability of the Body" *supra*, note 144, implied at 172; O'Malley, Robert D. "Emergency Surgical Procedures in Adult Jehovah's Witnesses" *The Journal of Abdominal Surgery*, 160, (June 1967); Watchtower Bible and Tract Society, *Jehovah's Witnesses and the Question of Blood*, 26 (1977).

147. *R. v. Steele* (1952) 102 C.C.C. 273.

148. Waltz and Inbau, *Medical Jurisprudence*, *supra*, note 144 at 144.

149. *Ibid.*, at 143.

150. *R. v. Bourne*, *supra*, note 13, Macnaghten J. (dicta).

151. Canadian Medical Association, *Code of Ethics*, 1978, Responsibilities to the Patient, sections 14-16.

152. *Criminal Code*, section 228:

> Every one who, with intent
> (*a*) to wound, maim, or disfigure any person,
> (*b*) to endanger the life of any person, or
> (*c*) to prevent the arrest or detention of any person,
> discharges a firearm, air gun, or air pistol at or causes bodily harm in any way to any person, whether or not that person is the one mentioned in paragraph (*a*), (*b*) or (*c*), is guilty of an indictable offence and is liable to imprisonment for fourteen years.

153. *R. v. Hostetter* (1902) 5 Terr. L.R. 363, 7 C.C.C. 221; *R. v. Wood* (1830) 1 Mood. C.C. 278, 168 E.R. 1271; *R. v. Beckett* (1836) 1 M. & Rob. 526,

174 E.R. 181; *R. v. McLaughlin* (1838) 8 Car. & P. 635, 173 E.R. 651; *R. v. Smith* (1837) 8 Car. & P. 173, 173 E.R. 448.

154. *R. v. Schultz* (1962) 39 W.W.R. 23.

155. Tremeear's Criminal Code, *supra*, note 89 at 346; Lagarde, *Droit Pénal Canadien*, *supra*, note 89 at 561.

156. *Criminal Code*, section 202:

(1) Every one is criminally negligent who
(*a*) in doing anything, or
(*b*) in omitting to do anything that it is his duty to do,
shows wanton or reckless disregard for the lives or safety of other persons.

(2) For the purposes of this section, 'duty' means a duty imposed by law.

Criminal Code, section 203:

Every one who by criminal negligence causes death to another person is guilty of an indictable offence and is liable to imprisonment for life.

Criminal Code, section 204:

Every one who by criminal negligence causes bodily harm to another person is guilty of an indictable offence and is liable to imprisonment for ten years.

157. *St. Germain v. R.*, *supra*, note 26; *Peda v. R.* (1969) 7 C.R.N.S. 243, per Cartwright; Burns, Peter, "An Aspect of Criminal Negligence or How the Minotaur Survived Theseus Who Became Lost in the Labyrinth", 48 *Canadian Bar Review*, 47, (1970), at 63. The elements of criminal negligence are the topics of considerable academic debate at present. Burns' article is a plea for recognition of the mental element. The courts' tendency to subsume "recklessness" into the objective evaluation of conduct is eroding the mental element requirement.

158. *Criminal Code*, subsection 202(2), *supra*, note 156.

159. *St. Germain v. R.*, *supra*, note 26.

160. *Criminal Code*, section 197; *supra*, notes 91, 92, 93, 95, 96; *Criminal Code*, section 198, 199, *supra*, note 111.

161. *Leblanc v. R.* [1977] S.C.R. 339, 1970 (1975) 29 C.C.C. 2d 975.

162. *Food and Drugs Act*, R.S.C., c. F-27, Amended by 1976-77, c. 28 and Regulations.

163. *Narcotic Control Act*, R.S.C. 1970, c. N-1, amended by 1972, c. 17, 1974-75-76, c. 48 and Regulations.

164. *Penitentiary Act*, R.S.C. 1970, c. P-6 and Regulations.

165. Narcotic Control Regulations, P.C. 1972-1033, May 16, 1972, section 38:

(1) No practitioner shall administer, prescribe, give, sell, or furnish a narcotic to any person or animal except as provided in this section.

(2) Subject to subsection (3), a practitioner may administer, prescribe, give, sell or furnish a narcotic to a person or animal if

a) the person or animal is a patient under his professional treatment; and

b) the narcotic is required for the condition for which the person or animal is receiving the treatment.

166. Penitentiary Regulation 2.06, SOR/62-90, *The Canada Gazette*, Part II, Volume 96, March 28, 1962, No. 6.

167. Vandervort, Lucinda "Legal Aspects of the Medical Treatment of Penitentiary Inmates", *supra*, note 134 at 369-70.

168. *St. Germain v. R.*, *supra*, note 26.

169. Chart of Human Rights and Freedoms, S.Q. 1975, c. 6, s. 2. There appears to be no similar duty of affirmative action in the other provinces. See also: *St. Germain v. R.*, *ibid.*; Règlements de la corporation du Collège des médecins, *Gazette officielle du Québec*, No. 3391, October 6, 1971, no. 45, Nov. 6, 1971.

170. In *Leblanc v. R.*, (1971) 19 C.R.N.S. 54, in the Québec Court of Appeal, Rivard J.A. (dissenting) said that the judge failed to instruct on the degree of negligence required to render the act criminal. This point went on appeal to the Supreme Court of Canada but was unanimously rejected, *supra*, note 161.

171. *R. v. Senior*, *supra*, note 101.

172. *St. Germain v. R.*, *supra*, note 26.

173. *Dame Bergstrom et Vir. V.G.* [1967] G.S. 513.

174. Burns, Peter "An Aspect of Criminal Negligence or How the Minotaur Survived Theseus Who Became Lost in the Labyrinth", *supra*, note 157, at 49; see the development in the following cases: *O'Grady v. Spraling* [1960] S.C.R. 804; *Binus v. R.* [1967] S.C.R. 594, [1968] 1 C.C.C. 227; *Peda v. R.*, *supra*, note 157; *R. v. Arthurs* [1974] S.C.R. 287, (1972) 7 C.C.C. (3d) 438; *Leblanc v. R.*, *supra*, note 161. Note, however, that *O'Grady v. Spraling*, *Binus v. R.*, and *Peda v. R.* involved criminal negligence in the operation of a motor vehicle and were distinguished on that basis by Laskin J. (dissent) in *R. v. Arthurs* at 306 and by de Grandpré J. in *Leblanc v. R.* at 356.

175. *Leblanc v. R.*, *ibid.*, at 356.

176. *Arthurs v. R.*, *supra*, note 174, at 292; affirmed *Leblanc v. R.*, *ibid.*, at 355.

177. In *Leblanc v. R.*, *ibid.*, de Grandpré J. for the majority accepted that deliberation was not required (355) and then went on to admit similar fact evidence of *mens rea* or guilty intent.

178. In a broad sense, the comments criticize the movement towards "objective *mens rea*" because it usurps the traditional requirement that a

crime consists of *actus reus* and *mens rea*, it upsets the apparent policy of the Code to do away with imputed intent, it confuses *actus reus* with *mens rea*, and it confuses evidential requirements with substantive criminal law. Burns, "An Aspect of Criminal Negligence or How the Minotaur Survived Theseus Who Became Lost in the Labyrinth" *supra*, note 157; "Criminal Law: The General Part" Working paper for the Law Reform Commission of Canada, to be published; Stuart, Don "The Need to Codify Clear, Realistic and Honest Measures of *Mens Rea* and Negligence" 15, *Criminal Law Quarterly*, 160 (1972-73); Weiler, Paul "The Supreme Court of Canada and the Doctrines of *Mens Rea*" 49 *Canadian Bar Review*, 280, (1971).

179. *R. v. Rogers*, *supra*, note 119, at 214.

180. *St. Germain v. R.*, *supra*, note 26.

181. Stuart, Don "The Need to Codify Clear, Realistic and Honest Measures of *Mens Rea* and Negligence" *supra*, note 178, at 166; Williams, *Criminal Law*, *supra*, note 74, at 58.

182. This uncertainty was criticized with regard to decisions which arise within the abortion procedure, and particularly the case of *State v. Edelin* where a doctor was charged with manslaughter for failure to treat an allegedly live-born fetus. Robertson, John A. "After Edelin: Little Guidance" (1977) *Hastings Center Report*, 15 (June), at 17.

183. *Ibid.* This consideration is of primary importance for recklessness within the homicide provisions of the Code. The present uncertain state of the law as to intent for criminal negligence plus the lack of guidelines on quality of life issues leave doctors theoretically vulnerable to serious criminal charges. See, for example, the recent controversy over the case of a severely deformed newborn who was allowed to die in a British Columbia hospital. *The Globe and Mail*, Wednesday, August 16, 1978, page 11; *Ottawa Gazette*, August 16, 1978, page 4.

184. *Criminal Code*, sections 203, 204 (respectively), *supra*, note 156.

185. In Kansas where there is a definition of death as brain death, an appeal court recently upheld a conviction for murder despite the turning off of the respirator because the definition of death had not been fulfilled (*State v. Shaffer* (1978) 574 P. 2d 205). In *R. v. Kitching and Adams* (1976) 32 C.C.C. (2d) 160 (Manitoba Court of Appeal, leave to appeal to S.C.C. dismissed), it was found that there may be two or more operative causes of death. The problem has also arisen in England where doctors switched off the life-support machine for a young woman clinically dead after a brutal sexual attack. (*The Ottawa Citizen*, Saturday, October 15, 1977).

186. This is the opinion of the Law Reform Commission of Canada in its Working Paper, *The Definition of Death* (1979). See also Manitoba Law Reform Commission, *Report on a Statutory Definition of Death*, Winnipeg, 1974. For affirmation of the uncertainty raised by these questions, see Smith and Hogan, *Criminal Law*, *supra*, note 37, at 213; Williams, *The Sanctity of Life and the Criminal Law*, *supra*, note 14, at 18; Elliott, 4 *Medical Science and Law* 77 (1964); Kennedy, I. M., "Alive or

Dead", 22 *Current Legal Problems*, 102, (1969); Hogan, "A Note on Death", [1972] *Criminal Law Reports* 80.

187. Turner, *Kenny's Outlines of Criminal Law*, *supra*, note 25 at 20; Turner, *Russell on Crime, supra*, note 37, at 28; see also Hart, H. L. A. and Honoré, A. M. *Causation in the Law*, 85, (1959).

188. *Ibid.*; Smith and Hogan, *Criminal Law*, *supra*, note 37, at 38.

189. Hart and Honoré, *Causation in the Law*, *supra*, note 187, at 104; Smith and Hogan, *ibid.*, at 215; *Smithers v. R.* (1977) 40 C.R.N.S. 79 at 89.

190. *Criminal Code*, section 207:

> Where a person, by an act or omission, does anything that results in the death of a human being, he causes the death of that human being notwithstanding that death from that cause might have been prevented by resorting to proper means.

Criminal Code, section 208:

> Where a person causes to a human being a bodily injury that is of itself of a dangerous nature and from which death results, he causes the death of that human being notwithstanding that the immediate cause of death is proper or improper treatment that is applied in good faith.

191. *Criminal Code*, section 209:

> Where a person causes bodily injury to a human being that results in death, he causes the death of that human being notwithstanding that the effect of the bodily injury is only to accelerate his death from a disease or disorder arising from some other cause.

192. *Criminal Code*, section 210:

> No person commits culpable homicide or the offence of causing the death of a human being by criminal negligence unless the death occurs within one year and one day commencing with the time of the occurrence of the last event by means of which he caused or contributed to the cause of death.

193. *St. Germain v. R.*, *supra*, note 26. However, Lagarde, *Droit Pénal Canadien*, *supra*, note 89, at 481 is of the opinion that sections 207 and 208 apply to criminal negligence causing death, although no cases are cited. These sections may apply because criminal negligence is an included offence in homicide, according to an application of *Prosser v. R.* (1959) 127 C.C.C. 111, 33 C.R. 253 and subsection 205(5) of the Code. However, for purposes of discussion, the assumption is made that they do not apply and will, therefore, be discussed within homicide.

194. *R. v. Ferguson* (1964) 44 C.R. 20; *R. v. Watson*, (1936) 66 C.C.C. 233; *St. Pierre v. R.* [1967] B.R. 695 (Que. C.A.); *St. Germain v. R.*, *supra*, note 26.

195. *R. v. Watson*, *ibid.*; *St. Pierre v. R.*, *ibid.*; *St. Germain v. R.*, *ibid.*

196. *St. Germain v. R.*, *ibid.*

197. *People v. Phillips* (1966) 414 P. 2d 353; Smith and Hogan, *Criminal Law*, *supra*, note 37 at 217; *Smithers v. R.*, *supra*, note 189 at 90; *R. v. Morley*, supra, note 104; R. v. Homeberg, supra, note 114.

198. *St. Pierre v. R.*, *supra*, note 194; *People v. Phillips*, *ibid.*; *St. Germain v. R.*, *supra*, note 26; *Smithers v. R.*, *supra*, note 189, at 87.

199. This reasoning is based on the common law origins of sections 207, 208, 209 of the Code and the arguments of note 193, *supra*.

200. Hart and Honoré, *Causation in the Law*, *supra*, note 187 at 318; *Smith and Hogan*, Criminal Law, *supra*, note 37, at 221.

201. *Ibid.*, at 320 and 222 respectively; *Smithers v. R.*, *supra*, note 189 at 91; *R. v. Blane* [1975] 1 W.L.R. 1411, [1975] 3 All E.R. 446.

202. *Ibid.* See also Part D, section 2, below in text.

203. *Criminal Code*, subsection 205(5):

> A person commits culpable homicide when he causes the death of a human being
> (*b*) by criminal negligence,

204. *Criminal Code*, subsection 205(5):

> A person commits culpable homicide when he causes the death of a human being
> (*a*) by means of an unlawful act

205. *Criminal Code*, paragraphe 205(5)(*b*), *supra*, note 203.

206. *R. v. Tennant and Naccarato* (1975) 23 C.C.C. (2d) 80, (1975) 7 O.R. (2d) 687, 31 C.R.N.S. 1 (Ont. C.A.); *R. v. Lelièvre* [1962] O.R. 522, 132 C.C.C. 288, 32 O.L.R. (2d) 723; Stuart, Don, "Background Homicide Study", unpublished paper prepared for Law Reform Commission of Canada, 1977, at 11.

207. *R. v. Alec* (1974) 17 C.C.C. (2d) 529 (S.C.C.); *Smithers v. R.*, *supra*, note 189.

208. *Criminal Code*, section 212:

> Culpable homicide is murder
> (*a*) where the person who causes the death of a human being
> (i) means to cause his death,

209. *Criminal Code*, section 212:

> Culpable homicide is murder
> (*a*) where the person who causes the death of a human being
> (ii) means to cause him bodily harm that he knows is likely to cause his death, and is reckless whether death ensues or not;

210. *R. v. Tennant*, *supra*, note 206; *R. v. Henry* (1974) 30 C.R.N.S. 15, 19 C.C.C. (2d) 112 (N.S.C.A.); *R. v. Mack* [1975] 4 W.W.R. 180, 29 C.R.N.S. 270, 22 C.C.C. (2d) 257 (Alta. C.A.).

211. *R. v. Tennant*, *ibid.*

212. Turner, *Russell on Crime*, *supra*, note 37, at 458; Gordon, Gerald H. "Subjective and Objective *Mens Rea*" 17 Criminal Law Quarterly 355, (1974-75), at 385.

213. Smith and Hogan *Criminal Law*, *supra*, note 37, at 53.

214. *People v. Phillips*, *supra*, note 197; see also "The First Recorded Murder Conviction of A Medical Quack" 28 *Connecticut Medicine*, 492, (July 1964).

215. *Behavior To-day*, 9:10, March 20, 1978. The case of Dr. Mario E. Jascalevich.

216. *Criminal Code*, section 217:

> Culpable homicide that is not murder or infanticide is manslaughter.

217. *R. v. Kuzmack* (1955) 11 C.C.C. 1, 20 C.R. 377 (S.C.C.).

218. *R. v. Spiller* (1832) 5 C. & P. 333; *R. v. Simpson* (1829) 1 Lew C.C. 172; *R. v. Ferguson* (1830) 1 Lew C.C. 181; *R. v. Long* (1831) 4 C. & P. 398; *R. v. Spilling* (1838) 2 Mood. & R. 107; *R. v. Webb* (1834) 2 Lew C.C. 196; *R. v. Chamberlain* (1867) 10 Cox C.C. 486; *R. v. Watson*, *supra*, note 194. For clarification, note that manslaughter by criminal negligence and criminal negligence itself are separate offences.

219. For a discussion of this problem within the American context, see "Notes: Scarce Medical Resources" 69 *Columbia Law Review* 620 (1969), at 624; Sanders, David and Dukeminier, Jesse "Medical Advance and Legal Lag: Haemodialysis and Kidney Transplantation" *supra*, note 144.

220. "Notes: Scarce Medical Resources", *ibid.*, at 625.

221. The Commission thanks Professor Bernard Dickens, Faculty of Law, University of Toronto for this opinion.

222. All defences available at common law are available in the *Criminal Code* according to s. 7(3).

223. The unity of offence and defence as indicative of legality is an application of Hall and his stance against the bifurcation of criminal theory. Hall, Jerome *General Principles of Criminal Law*, (2nd ed. 1960), chapter 1 at 14 and chapter 7 at 233.

224. *Ibid.*, at 233; but see Arnolds, Edward B. and Garland, Norman F. "The Defence of Necessity in Criminal Law: The Right to Choose the Lesser Evil" 65 *Journal of Criminal Law and Criminology* 289 (1974). Arnolds and Garland argue that justification goes to ultimate legality but an excuse does not. Hall at 236 says that this is an "unawarranted assumption".

225. Hall, *General Principles of Criminal Law*, *supra*, note 223.

226. *Criminal Code*, section 45, *supra*, note 24.

227. *Morgentaler v. R.*, *supra*, note 12, at 676 per Dickson J. demonstrating the inapplicability of section 45 to section 251: "We must give the sections a reasonable construction and try to make sense and not nonsense.

We should pay Parliament the respect of not assuming readily that it has enacted legislative inconsistencies or absurdities." For special material dealing with the scope of section 45, see Starkman, Bernard, "A Defence. . .", *supra*, note 43.

228. *Ibid.*, per Dickson at 675.

229. See *supra*, note 39.

230. Stephen, *Digest of the Criminal Law*, article 226, (6th ed.); also Draft Code of 1880, s. 67.

231. *Morgentaler v. R.*, *supra*, note 12 per Laskin C.J. at 644.

232. *Ibid.*, at 647.

233. *Ibid.*, per Dickson with majority approval at 676; Mayrand, Albert, *L'Inviolabilité de la Personne Humaine*, 46 [1975]; *Laporte v. Laganière*, *supra*, note 59, at 361.

234. Although Stephen, *Digest of the Criminal Law*, *supra*, note 36, contained a section similar to section 45, it must be read in conjunction with two other provisions:

> Article 288 — *Right to Consent to Bodily Injury for Surgical Purposes*
>
> Every one has a right to consent to the infliction of any bodily injury in the nature of a surgical operation upon himself or upon any child under his care and too young to exercise a reasonable discretion in such a matter, but such consent does not discharge the person performing the operation from the duties hereinafter defined in relation thereto.
>
> Article 289 — *Surgical Operation on Person Incapable of Assent*
>
> If a person is in such circumstances as to be incapable of giving consent to a surgical operation, or to the infliction of other bodily harm of a similar nature and for similar objects, it is not a crime to perform such operation or to inflict such bodily harm upon him without his consent or in spite of his resistance. For an analysis of section 45 in the light of its precursors in Stephen's *Digest*, see Starkman, B., "A Defence. . .", *supra*, note 43

235. Williams, *Criminal Law*, *supra*, note 74, at 732; Hughes, "Two Views on Consent in the Criminal Law", *supra*, note 49, at 237.

236. *Marshall v. Curry*, *supra*, note 30; *Murray v. McMurchy* [1949] 2 D.L.R. 442, [1949] 1 W.W.R. 989; Wright and Linden, *Canadian Tort Law*, *supra*, note 123, at 93.

237. Somerville, Margaret, A., *Consent to Medical Care*, study paper for the Law Reform Commission of Canada (November, 1979); Starkman, "Preliminary Study. . ." *supra*, note 43, at 1; Fried, Charles, "Moral Causation", 77 *Harvard Law Review*, 1258 (1963-64).

238. Fried, Charles, "Moral Causation", *ibid.*, at 1265.

239. Veatch, Robert M. "Professional Medical Ethics: The Grounding of its Principles", 4(1) *Journal of Medicine and Philosophy* 4 (March, 1979).

240. Leigh, L. H. "Necessity and the Case of Dr. Morgentaler" [1978] *Criminal Law Review* 151 at 154.

241. "Notes: Medical Treatment and Human Experimentation: Introducing Illegality, Fraud, Duress and Incapacity to the Doctrine of Informed Consent" 6 *Rutgers-Camden Law Journal* 538, (1975), at 543.

242. Québec Civil Code, Article 20; Mayrand, *L'inviolabilité de la Personne Humaine*, *supra*, note 233, at 16; Williams, *Sanctity of Life and the Criminal Law*, *supra*, note 14, at 287.

243. Fisher, T. L. "Legal Implications of Sterilization" 91 *Canadian Medical Association Journal*, 1363 (1964), at 1364.

244. Sharpe, G. S. "The Minor Transplant Donor" 7:1 *Ottawa Law Review* 85, (1975), at 97; but see also cases where donor transplant surgery was denied as being against incompetent donor's best interest because it was not established that there was urgent need for the transplant, there was no reasonable alternative, and there was minimum uncertainty. *In Re Richardson*, 284 So. 2d 185; "Surgical Transplants — Permission for Performing a Kidney Transplant Denied as Against Incompetent Donor's Best Interest" 5 *Cumberland-Sanford Law Review* 163, (1975); Castel, J.-G. "Some Legal Aspects of Human Organ Transplantation in Canada" 46(3) *Canadian Bar Review* 345, (1963), at 365 (ftnt. 50).

245. McCormick, Richard A. "Transplantation of Organs: A Comment on Paul Ramsey" 36(3) *Theological Studies* 503 (1975).

246. Some non-meritorious procedures such as tonsillectomy are outlined by Hiatt, Howard H. "Protecting the Medical Commons: Who is Responsible?" 293(5) *New England Journal of Medicine* 235 (1975).

247. *Ibid.*; Friedman, Lawrence J. "Editorial: Is Mutilating Surgery 'Necessary' to Relieve Anxiety" 5(9) *Legal Aspects of Medical Practice* 4(1977); "How to Avoid Operations" 12(6). *Trial* (1976); Saskatchewan Association on Human Rights, *Needless Surgery* (1975); Vayda, Eugene "A Comparison of Surgical Rates in Canada and in England and Wales" 289 *New England Journal of Medicine* 1224 (1973); Lewis, Charles E. "Variations in the Incidence of Surgery" 281 *New England Journal of Medicine* 880 (1969).

248. Carter, R. F. *Criminal Law of Queensland* (1969) (Criminal Code of Queensland, section 282).

249. Dickens, *Abortion and the Law*, *supra*, note 14, at 50.

250. A Cornell University study indicated that 11% to 13% of elective procedures would be permanently deferred with a second consultation. The American Medical Association opposes this view. "How to Avoid Operations", *supra*, note 247.

251. *Morgentaler v. R.*, *supra*, note 12, per Laskin C.J. at 650-1.

252. *Morgentaler v. R.*, *ibid.*, per majority; Leigh "Necessity and the Case of Dr. Morgentaler", *supra*, note 240, at 153.

253. Glazebrook, P. R., "The Necessity Plea in English Criminal Law", 30(1) *Cambridge Law Journal* 87 (1972); Smith and Hogan, *Criminal*

Law, *supra*, note 37 at 159; Turner, *Russell on Crime*, *supra*, note 37, at 93; *R. v. Dudley and Stephens* (1884) 14 Q.B.C. 273. These opinions stress that although necessity is not a defence in the strict sense, the plea is recognized in various juristic techniques related to the form and content of the definition of offences. Such techniques include: a) the presumption that if compliance with the law causes more harm, then the law is not intended to apply, b) words of justification such as "reasonable" and "unlawful" in the offence, c) the assumption of consent if reasonable in the absence of express refusal, and d) the inclusion of provisos.

254. *R. v. Byng* (1977) 20 N.S.R. (2d) 125; *Morgentaler v. R.*, *supra*, note 12; *R. v. Paul* (1973) 12 C.C.C. (2d) 497; *R. v. Kennedy* (1972) 7 C.C.C. (2d) 42; Leigh, "Necessity and the Case of Dr. Morgentaler", *supra*, note 240.

255. Williams, Glanville "The Defence of Necessity", 6 *Current Legal Problems* 216 (1953); Williams, *Criminal Law*, *supra*, note 74, at 724; Williams, Glanville, "Necessity", [1978] *Criminal Law Review* 128; Turner, *Kenny's Outlines of Criminal Law*, *supra*, note 25, at 72; Hughes, "Two Views on Consent in the Criminal Law", *supra*, note 49, at 237; Huxley, P. H. J. "Proposals and Counter Proposals on the Defence of Necessity" [1978] *Criminal Law Review* 141.

256. Hall, *General Principles of Criminal Law*, *supra*, note 223, at 433; Arnolds and Garland, "The Defence of Necessity in Criminal Law", *supra*, note 224; Sanders and Dukeminier, "Medical Advance and Legal Lag: Haemodialysis and Kidney Transplantation", *supra*, note 144, at 384; Annas, George J. "Allocation of Artificial Hearts in the Year 2002: Minerva v. National Health Agency" 3:1 *American Journal of Law and Medicine* 59 (1977) at 68.

257. *Morgentaler v. R.*, *supra*, note 12, at 678, Dickson J. for the majority.

258. *Ibid.*, at 680.

259. *Ibid.*, at 681; Turner, *Kenny's Outlines of Criminal Law*, *supra*, note 25, at 72; Arnolds and Garland, "The Defence of Necessity in Criminal Law", *supra*, note 224, at 294.

260. Williams, *Criminal Law*, *supra*, note 74, at 746.

261. *Ibid.*, at 782; Hughes, "Two Views on Consent in the Criminal Law", *supra*, note 49, at 237. Those who deny the existence of the defence base the legitimacy of the intervention on the doctrine of implied consent based on reasonableness and the avoidance of greater evil (Glazebrook, "The Plea of Necessity in English Criminal Law", *supra*, note 253, at 103).

262. *R. v. Adams* (1957 unreported); see Williams, *ibid.*, at 726.

263. *R. v. Dudley and Stevens*, *supra*, note 253.

264. *U.S. v. Holmes* (1842) 26 Fed. Cas. 360; Arnolds and Garland, "The Defence of Necessity in Criminal Law", *supra*, note 224, at 295.

265. *Ibid.*

266. The split is the same as in *supra*, notes 253 and 254. Those who pigeonhole *Dudley and Stephens* do so because of the particularly gruesome facts in the case which may have clouded judgment.

267. Annas, George "Allocation of Artificial Hearts in the Year 2002: Minerva v. National Health Agency" *supra*, note 256, at 68.

268. *Criminal Code*, subsection 221(2):

> [Murder by killing of an unborn child in the act of birth] does not apply to a person who, by means that, in good faith, he considers necessary to preserve the life of the mother of a child, causes the death of such child.

269. See, for example, reference to a recent American case wherein the cousin of a critically ill man could not be forced to submit to a bone marrow transplant. "Marrow needed — Rescue no duty: Judge" *The Citizen*, Ottawa, July 27, 1978.

270. Huxley, P. H. J., "Proposals and Counter Proposals on the Defence of Necessity", *supra*, note 255, at 143; Glazebrook, "The Necessity Plea in English Criminal Law", *supra*, note 253, at 99. In *Director of Public Prosecutions for Northern Ireland v. Lynch* [1975] A.C. 653, the House of Lords held that duress was an absolute defence to a principal charged with murder in the second degree. However, the effect of this case has been curtailed by *Abbott v. R.* [1977] A.C. 755. In the subsequent case, the Privy Council said that duress was not a defence to a charge of murder against anyone proved to have done the actual killing.

271. *Leigh v. Gladstone and others* (1909) 26 T.L.R. 139; Williams, *Criminal Law*, *supra*, note 74, at 733.

272. Williams, *ibid.*

273. *Ibid.*; see also Glazebrook "The Necessity Plea in English Criminal Law" *supra*, note 253, at 99. The British government announced in 1974 that there would be no more forced feeding of prisoners provided the prisoner was competent. The practice, however, continued until medical doctors refused to force-feed. (See Zellick, Graham, "The Forcible Feeding of Prisoners: An Examination of the Legality of Enforced Therapy" (1976) *Public Law* 153; for an American view see Bomstein, Michael S., "The Forcible Administration of Drugs of Prisoners and Mental Patients" (1975) 9 *Clearinghouse Review* 379 (October)).

274. Vandervort, Lucinda, *supra*, note 134.

275. See Glazebrook, *supra*, note 253, at 103. Devlin, Patrick, *Samples of Lawmaking*, 93 (1962).

276. Refer to *supra*, note 253.

277. Williams, "Necessity", *supra*, note 255, at 134.

278. *United States v. Randall* (1976) 104 Daily Washington Law Reports 2249; "Medical Necessity as a Defense to Criminal Liability: United States v. Randall" 46 *George Washington Law Review* 273 (1978). The medical necessity case has been recognized in Canada in *R. v. Byng*, *supra*, note 254, but the values were not predetermined.

279. "Medical Necessity as a Defense to Criminal Liability: United States v. Randall" *ibid.*, at 292.

280. *Ibid.*, at 294.

281. *Wilson v. Inyang* [1951] 21 C.B. 799, [1951] 2 All E.R. 237; *R. v. Rees* (1956) 115 C.C.C. 1, 4 D.L.R. (2d) 406, [1956] S.C.R. 640; *Beaver v. R.* (1957) 118 C.C.C. 129, [1957] S.C.R. 531, 26 C.R. 193; *R. v. Custeau* (1971) 6 C.C.C. (2d) 179; *R. v. Davidson* (1971) 3 C.C.C. (2d) 509, [1971] 4 W.W.R. 731; *R. v. Couture* (1976) 33 C.C.C. (2d) 74.

282. *Beaver v. R.*, *ibid.*, per Cartwright J. at 137 (C.C.C.) and at 538 (S.C.R.). But see, Stuart, "The Need to Codify Clear Realistic and Honest Measures of Mens Rea and Negligence", *supra*, note 178, who identifies the tendency in the opposite direction. However, Stuart relied on cases of strict liability to come to his conclusion and did not take note of *Beaver v. R.*. For another opinion on strict liability, see *R. v. Sault Ste. Marie* [1978] S.C.R. (3d) 30 at 44; *R. v. Couture*, *ibid.*; Smith and Hogan, *Criminal Law*, *supra*, note 37, at 148.

283. There are several American examples. *Throne v. Wandell* (1922) 176 Wisc. 97, 186 N.W. 146; *Ehlen v. Burrows* (1942) 51 Cal. App. 2d 141, 124 P 2d 82; *Hershey v. Peake* (1924) 115 Kan. 562, 223 Pac. 1113; *Samuelson v. Taylor* (1931) 160 Wash. 369, 295 Pac. 113; *Gill v. Selling* (1928) 125 Ore. 587, 267 Pac. 812, 58 A.L.R. 1556; *Necolayff v. Genesee Hospital* (1947) 296 N.Y. 936, 73 N.E. 2d 117; *Sullivan v. McGraw* (1898) 118 Mich. 39, 76 N.W. 149; see also McCoid, Allan H., "A Reappraisal of Liability for Unauthorized Medical Treatment" 41(4) *Minnesota Law Review* 381 (1957) at 418.

284. *R. v. Spencer* (1867) 10 Cox C.C. 525; *R. v. Giardine*, *supra*, note 127.

285. *R. v. Giardine*, *ibid.*, at 300.

286. Turner, *Kenny's Outlined of Criminal Law*, *supra*, note 25, at 60; Turner, *Russell on Crime*, *supra*, note 37, at 75; *R. v. Machekequonabe* (1896) 28 O.R. 309.

287. *R. v. Wagstaffe* (1868) 10 Cox C.C. 530; *R. v. Hurry* (1872) 76 Cent. Crim. Ct. 63; *R. v. Hines* (1874) 80 Cent. Crim. Ct. 309; Trescher, Robert L. and O'Neill, Thomas N. "Medical Care for Dependent Children: Manslaughter Liability of the Christian Scientist". 109 *University of Pennsylvania Law Review* 203 (1961) at 208. As law developed, specific statutory rules were invoked to cover each example of religious belief.

288. Turner, *Kenny's Outlines of the Criminal Law*, *supra*, note 25, at 60; Turner, *Russell on Crime*, *supra*, note 37, at 76.

289. Smith and Hogan, *Criminal Law*, *supra*, note 37, at 170; Turner, *Kenny's Outlines of Criminal Law*, *supra*, note 25, at 66; Turner, *Russell on Crime*, *supra*, note 37, at 87; Williams, *Criminal Law*, *supra*, note 74, at 296.

290. *Reference re Validity of Section 5(a) of the Dairy Industry Act* [1949] S.C.R. 1 at 49-50; see also *Morgentaler v. R.*, *supra*, note 12, per Laskin J. at 625.

291. *Supra*, note 3, at 33.

292. Law Reform Commission of Canada, *Our Criminal Law*, *supra*, note 3, at 5; Hall, *General Principles of Criminal Law*, *supra*, note 223, at 215.

293. This attitude has been expressed in France and in Germany. See, Somerville, Margaret, *Consent to Medical Care*, study paper for the Law Reform Commission of Canada, 1979; *The German Draft Penal Code*, *supra*, note 52, at article 161. Note, however, that the German theory is apparently narrower in confining the absence to physical harm. The French attitude appears to recognize all normal treatments as therapeutic and therefore not harmful. See also Dworkin, *supra*, note 37, at 357; Daube, David, *Ethics in Medical Progress* (1966) at 193.

294. *The Globe and Mail*, October, 1977; Gibbs, *supra*, note 2. This stance is further supported by studies which indicate higher death rates where there are more doctors, more specialists, more hospital beds (*Behavior To-day* Vol. 9, no. 10, March 20, 1978, Cornell University) and statistics on deaths resulting from unnecessary surgery (11,900 deaths in 1975 in U.S.A.) (Congressional Report, January 19, 1976, in Sobel, Lester (ed.) *Medical Science and the Law: The Life and Death Controversy*, (1977).

295. *State v. Schulz* (1881) 55 Iowa 628, 8 N.W. 469; Ladimer, Irving "Ethical and Legal Aspects of Medical Research on Human Beings" 3 *Journal of Public Law* 467 (1954) at 502.

296. *Supra*, note 1.

297. Arnolds and Garland, "The Defense of Necessity in Criminal Law: The Right to Choose the Lesser Evil", *supra*, note 224, at 298.

298. *Morgentaler v. R.*, *supra*, note 12, per Laskin C.J. at 645.

299. Tarshis, Carl Barry, "Liability for Psychotherapy" 30 *University of Toronto Faculty of Law Review* 75 (1972), at 77.

300. Veatch, Robert M. "The Technical Criteria Fallacy" (1977) *Hastings Center Report*, 15, (August) at 16; Jacob, Joseph "The Right of the Mental Patient to His Psychosis" 39 *Modern Law Review* 17 (1976) at 35.

301. Fuller, Lon, "The Law's Precarious Hold on Life", 3 *Georgia Law Review* 530 (1969).

302. See the references to Hale, Blackstone and Coke, *supra*, note 115.

303. *R. v. Williamson*, *supra*, note 32; *Akerele v. R.* [1943] 1 All E.R. 367, [1943] 3 W.W.R. 167, [1943] A.C. 255.

304. Stephen in his *Digest of the Criminal Law*, *supra*, note 36, article 306 and 288 recognized the differential of professionalization in the special protection given surgical procedures, but gave no further reason for the difference.

305. Dworkin, "The Law Relating to Organ Transplantation in England", *supra*, note 37; Lord Kilbrandon in *Ethics in Medical Progress*, *supra*, note 293, (quoted in Dworkin, *ibid.*).

306. Note that in *A v. A* [1974] 1 All E.R. 755, "treat" meant "behave towards", in the context of treating a child as a member of one's family.

307. The Shorter Oxford English Dictionary (3rd ed. 1973); note that the words are inclusive so that additional conditions calling for treatment will be included according to the *ejusdem generis* rule of construction. A common meaning is taken to suggest broad application and avoidance of the substantial controversy on the scientific versus social meanings of these words (Engel, George L. "The Need for a New Medical Model: A Challenge for Biomedicine" 196 (4286) *Science* 129 (April 8, 1977).

308. Talcott Parsons described four essential factors in the sick role: nature and severity of illness, inability to control sickness by act of will, the expectation to get well as soon as possible, and the solicitation of appropriate help combined with individual co-operation. Parsons, Talcott, *The Social System* (1951); Siegler, Miriam and Osmond, Humphrey "The 'sick role' revisited" 1(3) *Hastings Center Studies* 41, (1973).

309. Illich, Ivan, *Medical Nemesis*.

310. Seigler and Osmond, *supra*, note 308, at 42.

311. Mechanic, David, "Health and Illness in Technological Societies" 1(3) *Hastings Center Studies* 7(1973) at 10.

312. Le Dain, Gerald, *A Report of the Commission of Inquiry into the Non-Medical Use of Drugs: Treatment*, Canada (1972).

313. *Dorland's Illustrated Medical Dictionary* (25th ed. 1974).

314. *R. v. Evans* (1916) 23 B.C.R. 128; *McDiarmid v. Elliott* [1934] 1 W.W.R. 504; *R. v. Oshanek* [1935] 2 W.W.R. 531, 43 Man. R. 234, 64 C.C.C. 219, [1935] 4 D.L.R. 632; *Hester v. Ford* (1930) 130 So. 203; *Kirschner v. Equitable Life Assurance Society of U.S.* (1935) 284 N.Y.S. 506; *Zipkin v. Freeman* (1969) 436 S.W. (2a) 753; *Wyatt v. Stickney* (1972) 344 F. Supp. 387; *Wyatt v. Aderholt* (1974) 503 F. 2d 1305; *Minister of Health v. Royal Midland Countries Home for Incurables Leamington Spa General Committee* [1954] 1 All E.R. 1013, per Denning dissent. For even wider definitions of treatment, see *Tanner and Another v. Jackson and Others* (1974) 23 F.L.R. 197 (Australia); *Minister of Health v. Royal Midland Counties Home for Incurables Leamington Spa General Committee*, *ibid.* per Evershed J.

315. *R. v. Homeberg*, *supra*, note 114, at 1062.

316. Community Pychiatric Hospitals Act, R.S.O. 1970, C. 74, s. 1(f); Children's Mental Hospitals Act, R.S.O. 1970, C. 69, s. 1(f); Sanatoria for Consumptives Act, R.S.O. 1970, C. 422, s. 1(g); Public Hospitals Act, R.S.B.C. 1960, C. 178, s. 2; Hospitals Act, R.S.P.E.I. 1974, C. H-11, s. 1(s); Medical Consent of Minors Act, N.B.A., C. M-6.1, s. 1; Public Hospitals Amendment Act, N.B.A. 1976, C. 49, s. 1.

317. Uniform Medical Consent of Minors Act, 1974 Proceedings of the Uniform Law Conference 120, s. 1.

318. Within the therapeutic context, the goals may differ. The aim may be a complete cure which includes the removal of causes and symptoms, or the compensation of factors which cause the sickness so the effects

of sickness are alleviated, or the suppression of symptoms. See Le Dain, *Report of the Commission of Inquiry into the Non-Medical Use of Drugs*, *supra*, note 312, at 6-7.

319. The specific considerations pertaining to these practices will be discussed by the Law Reform Commission in the following forthcoming Working Papers in the Protection of Life series: *Sterilization: Implications for Mentally Retarded and Mentally Ill Persons*, *Human Experimentation*, *Behavior Modification*.

320. Ladimer, Irving, "Ethical and Legal Aspects of Medical Research on Human Beings", *supra*, note 295; Fox, Renée C., "A Sociological Perspective on Organ Transplantation and Hemodialysis", (1970) *Annals of New York Academy of Sciences* 406; Kountz, Samuel L., "Clinical Transplantation — an Overview" 5 *Transplantation Proceedings* 59 (1973).

321. Fox, *ibid.*; Kountz, *ibid.*

322. Devlin, Patrick, *Samples of Lawmaking*, 84 (1962); Skegg, P. D. G. "Consent to Medical Procedures on Minors" 36 *Modern Law Review* 370 (1973) at 372.

323. *Criminal Code*, s. 45 defence applies only to surgical operations.

324. The separation of medicine and surgery originated in Arabian medicine with the opinion of Avengoar (1113-62) that surgery was unworthy of a physician. This tendency was manifest in the Middle Ages when, in some universities, candidates for medical degrees had to swear never to become surgeons. Surgery was considered an inferior art and unworthy of scholars. Catiglioni, Arturo, *A History of Medicine*, (1975).

325. It is generally recognized in criminal law theory that consent is not a defence; but the place and effect of consent has been much debated. See, for example Devlin, *The Enforcement of Morals* (1962) who argues that it is not a general defence.

326. Rubinstein, Amnon, "The Victim's Consent in Criminal Law: An Essay on the Extent of the Decriminalizing Element of the Crime Concept" in Wise, Edward, Mueller and Gerhard (eds.), *Studies in Comparative Criminal Law* 189 (1975) at 195.

327. In *Schloendorff v. The Society of the New York Hospital* (1914) 211 N.Y. 125 at 129, Cardozo, J. said: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; . . .".

328. For example, a defence is not provided for non-beneficial surgical interventions (*Criminal Code*, section 45).

329. Thomas Aquinus said in *Summa Theologica*, Pars 2a 2ae, Q. LXV, Act. 1. Conclusion: "The mutilation of anybody's limb shall not be permitted except on the part of law officers. As far as private persons are concerned such operation should only be performed with the consent of the person whose limb is involved and whose deteriorated limb would endanger the integrity of his whole body. The limb shall only be severed in order to improve the health of the entire body provided that no other

means are available to achieve this purpose." See, Nizsalavszky, E. *A Legal Approach to Organ Transplantation and Some Other Medical Actions*, Akadémiai Kiado: Budapest 1974 at 45.

330. Williams, Glanville "Consent and Public Policy" [1962] *Criminal Law Review* 154 at 159; Beale, J. H. "Consent in the Criminal Law" 8 *Harvard Law Review* 317 (1895) at 325.

331. See text *infra parte*, the discussion of *R. v. Donovan* and the recognized exceptions to assault.

332. *Halushka v. University of Saskatchewan et al.* (1965) 53 D.L.R. (2d) 436; *Kelly v. Hazlett* (1976) 15 O.R. (2d) 290; *Marshall v. Curry*, *supra*, note 30; *Reibl v. Hughes* 1:1 *Legal Medical Quarterly* 50 (1977) (reversed on other grounds by the Court of Appeal, (1979) 21 O.R. (2d) 14).

333. Holdsworth, Sir William *A History of English Law*, Vol. II, 455 and Vol. VIII, 306 (1966).

334. Nizsalavsky, *A Legal Approach to Organ Transplantation and Some Other Medical Actions*, *supra*, note 329, at 45-48. The religious attitudes are summarized as follows: Roman Catholic Church is not opposed to organ transplantation because it benefits fellow man, provided the right to refuse is always maintained; Protestant opinion favours experimentation provided it does not seriously endanger life or physical integrity and the test is previously sufficiently tried; the World Council of Churches in September 1968 approved experimentation if conducted according to guidelines; Judaism in general recognizes experimentation and transplantation upon consent and public approval.

335. The State of California has enacted the Natural Death Act, Part 1, Division 7, Health and Safety Code, c. 3.9, 1977 whereby an adult person may make a "written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition". This has spawned considerable debate about the basic presumptions of the doctor-patient relationship, the role of informed consent and the consequences of such declarations. See, for example, McCormick, Richard A. "Legislation and the Living Will" *America*, (March 12, 1977); Garland, Michael "Politics, Legislation and Natural Death" *Hastings Center Report*, (October 1976). Proposed Ontario legislation (Bill 3, 1977) is under consideration and there is no other legislation in Canada.

336. This causes some trouble for the requirement of knowledge in criminal law (informed consent in private law). However, it is suggested that this ultimately depends on the precision of the "living will" in relation to subsequent treatment. The uncertainty surrounding the use of "living wills" makes them generally undesirable at this time. See Kutner, Luis "The Living Will: Coping with the Historical Event of Death" 27(1) *Baylor Law Review* 39 (1975).

337. *The Canadian Abridgment* (2nd ed.) Vol. 25, "Medicine and Surgery" on *Male v. Hopmans* [1966] 1 O.R. 647, 54 D.L.R. (2d) 592.

338. *Marshall v. Curry*, *supra*, note 30, at 274.

339. Glazebrook, "The Necessity Plea in English Criminal Law", *supra*, note 253, at 103.

340. See *supra*, notes 254 and 255. In private law on the same point, see *Marshall v. Curry*, *supra*, note 30, at 274.

341. For further outline of the continuing consent theory, see Somerville, Margaret, *Consent to Medical Care*, *supra*, note 293.

342. Beale, "Consent in the Criminal Law", *supra*, note 330, at 320.

343. Somerville, *supra*, note 293.

344. *Bolduc v. Bird*, *supra*, note 71.

345. Somerville, *supra*, note 293.

346. *Supra*, notes 78 and 79. Also, *R. v. Harms* (1944) 81 C.C.C. 4, [1944] 2 D.L.R. 61, [1944] 1 W.W.R. 12.

347. *Burrell v. Harmer*, *supra*, note 79; Somerville, *supra*, note 293.

348. See Somerville, *supra*, note 293.

349. Uniform Medical Consent of Minors Act, *supra*, note 317, section 3.

350. Somerville, *supra*, note 293; Law Reform Commission of Canada, *Sterilization*, *supra*, note 319.

351. Law Reform Commission of Canada, *Sterilization*, *supra*, note 319.

352. Roth, Loren H., Meisel, Alan and Lidz, Charles W. "Tests of Competency to Consent to Treatment" 134(3) *American Journal of Psychiatry* 279 (March 1977). Five tests of competency have been classified by Roth as: 1) evidencing a choice; 2) "reasonable" outcome of choice; 3) choice based on rational process; 4) ability to understand; 5) actual understanding.

353. For example, the U.S. Department of Health, Education and Welfare recommends that actual understanding be required to consent to human experimentation (Fed. Register 39:30647-30657, Aug. 23, 1974) and California has made the same requirement for the use of electro-convulsive therapy (Roth, *ibid.*).

354. This technique has been used in the case of a Jehovah's Witness who refused blood transfusions. *Application of President and Directors of Georgetown College Inc.* (1964) 331 Fed. Rep. 2d 1000; see also Frenkel "Consent of Incompetents (Minors and the Mentally Ill) to Medical Treatment" 1(3) *Legal Medical Quarterly* 187 (1977). The practice has been condemned in *Holmes v. Silver Cross Hospital of Joliet Illinois* (1972) 340 F. Supp. 125.

355. Cases on a generalized finding of incompetency for the mentally ill are: *Whitree v. State* (1968) 56 Misc. 2d 693, 290 N.Y.S. 2d 486; *Kaimowitz v. Department of Mental Health*, No. 73-19434-AW (Wayne County Court, filed July 10, 1973). See also Frenkel, *ibid.*; "Adequate Psychiatric Treatment — A Constitutional Right?" 19 *Catholic Lawyer* 322 (1973); "Notes — Medical Treatment and Human Experimentation: Introducing Illegality, Duress, and Incapacity to the Doctrine of Informed

Consent" 6 *Rudgers — Camden Law Journal* 538 (1975). There is a basis against the mentally ill in provincial mental health and incompetency legislation whereby mental health legislation does not allow a court procedure for incompetency to manage one's estate, whereas it is the normal rule for general findings of incompetency (see below note 358).

356. Judicial support for the right to make unreasonable or foolish choices appears in *Smith v. Aukland Hospital Board* [1965] N.Z.L.R. 191 at 219; *Georgetown College*, *supra*, note 354, per Burger J.; *Mulloy v. Hop Sang* [1935] 1 W.W.R. 714; *Masuey v. Carter-Halls-Allinger Co. Ltd.* [1929] 3 W.W.R. 741. In *Masney*, Knowles J. asked for legislation "to protect such a man from his own foolishness", but none was enacted. Although Hughes, *supra*, note 49 took this view also, Kennedy, Ian "The Legal Effect of Requests by the Terminally Ill and Aged Not to Receive Further Treatment from Doctors" [1976] *Criminal Law Review* 217 took a more liberal approach. He recognized that American courts had shifted to a realization that "individual freedom here is guaranteed only if people are given the right to make choices which would generally be regarded as foolish ones".

357. This is the conclusion of more modern American cases: *Winters v. Miller* (1971) 446 F. 2d 65; *New York City Health and Hospital Corp. v. Stein* (1972) 335 N.Y.S. (2d) 461; *Wyatt v. Stickney* (1972) 344 F. Supp. 387. This is also the basic assumption in Ontario's Mental Health Act, S.O. 1978.

358. Patients' Estate Act, S.B.C. 1962, c. 44, s. 3, 4 (court order upon application); Mental Incompetency Act, R.S.O. 1960, c. 271, s. 4, 7, 9 (court order with provision for trial by jury); Incompetent Persons Act, R.S.N.S. 1967, c. 135, s. 2 (court order); Chancery Act, R.S.P.E.I. 1951, c. 21, s. 79, 80 (court order); Mentally Incompetent Persons' Estate Act, S. Nfld. 1970, c. 34, s. 3 (court order); The Dependent Adults Act, S.Alta. 1976, c. 63, s. 2, 3, 4, 5, 9 (court order upon application). Other legislation deals only with estates and not the person.

359. Law Reform Commission of Canada, *Report on Family Law*, Ottawa, 1976; also, Law Reform Commission of Canada, *The Family Court* (Working Paper), Ottawa, 1974.

360. Hughes, Graham, "Two Views on Consent in the Criminal Law, *supra*, note 49, at 236; Kearney, P. J. "Leukaemia in Children of Jehovah's Witnesses: Issues and Priorities in a Conflict of Care" 4 *Journal of Medical Ethics* 32, (1978); How, Glen, "Religion, Medicine and Law" 3 *Canadian Bar Journal* 365 (1960). The divergent interests are discussed in a case involving parental refusal of public education for their child (*Re D.J.M.S.* (a minor) [1977] 3 All E.R. 582 per Bruce, L.J. at 591). See also, Eeckelaar, "What are Parental Rights" 89 *Law Quarterly Review* 210 (1973); Bates, Frank "Parent and Child-Legal Intervention — Another Development" 61(3) *Canadian Bar Review* 516 (1978).

361. *In re Quinlan* (1976) 70 N.J. 10, 355 A. 2d 647.

362. *Superintendent of Belchertown State School v. Saikewicz* (1977) 370 N.E. 2d 417.

363. Annas, George J. "Judges at the Bedside: The Case of Joseph Saikewicz", *Medicolegal News*, Vol. 6, No. 1, 1978, 10; Curran, William J. "Law-Medicine Notes: The Saikewicz Decision", *The New England Journal of Medicine*, Vol. 298, No. 9, March 2, 1978, 499; Relman, Arnold S. "The Saikewicz Decision: Judges as Physicians" *The New England Journal of Medicine*, Vol. 298, No. 9, March 2, 1978, 508; Annas, George "After Saikewicz: No Fault Death" 8(3) *Hastings Center Report* 16 (June, 1978); Ramsey, Paul "The Saikewicz Precedent: The Courts and Incompetent Patients" 8(6) *Hastings Center Report* 36 (December, 1978).

364. For support of this view, see aspects of articles, *ibid.*, and also, Wright and Linden, *Canadian Tort Law*, supra, note 123 at 92; Marshall v. Curry, supra, note 30; Williams, Glanville, "Defences of General Application: The Law Commission's Report No. 83(2) Necessity" (1978) *Criminal Law Report* 128; Wadlington, Walter "Minors and Health Care: The Age of Consent" 11(1) *Osgoode Hall Law Journal* 115 (1973); Law Reform Commission of Canada, *Sterilization*, *supra*, note 319.

365. These could include the termination of life-support systems, sterilization, human experimentation, behavior modification and abortion.

366. Keyserlingk, Edward W., *Sanctity of Life or Quality of Life in the Context of Ethics, Medicine and Law*, (study paper for the Law Reform Commission of Canada), Ottawa, 1979; Law Reform Commission of Canada, *Cessation of Treatment* (forthcoming Working Paper).

367. *Criminal Code*, section 234.

368. *Criminal Code*, sections 465, 543, 608.2, 738(5), 738(6).

369. *Criminal Code*, section 545.

370. *Criminal Code*, section 546.

371. *R. v. Burns* [1965] 4 C.C.C. 298; Ratushny, Ed., "Is There a Right Against Self-Incrimination in Canada?" 19(1) *McGill Law Journal* 1 (1973).

372. *Laporte v. Laganière*, *supra*, note 59.

373. Note that the Road Traffic Act, Statutes of England, 1972, c. 20, section 7(1) specifically provides that the refusal to consent to the taking of blood to determine the proportion of alcohol in the body is to be considered as supporting any evidence given by the prosecution. Most importantly, however, the refusal itself is respected.

374. *R. v. Holland* (1841) 2 Moo. & R. 351; *R. v. Mubila* (1956) 1 S.A. 31; *R. v. Blaue* [1975] 3 All E.R. 446; Hart and Honoré, *Causation in the Law*, *supra*, note 187, at 320.

375. Some of the cases recognizing the right of refusal include: *Agnew v. Jobson* (1877) 13 Cox C.C. 625; *Masney v. Carter-Halls-Aldinger Co.*, *supra*, note 356; *Marshall v. Curry*, *supra*, note 30; *Mulloy v. Hop Sang*, *supra*, note 356; *Parmley v. Parmley & Yule* [1945] 4 D.L.R. 81 (S.C.C.); *Murray v. McMurchy* [1949] 2 D.L.R. 442; *Beausoleil v. La Communauté de Soeurs de la Charité de la Providence* [1965] 13 R. 37; *Smith v. Aukland Hospital Board*, *supra*, note 356; *Villemure v. l'Hôpital*

Notre-Dame and Turcot [1973] S.C.R. 716. An American case is: *In re Estate of Brooks* (1965) 32 Ill. 2d 361, 205 N.E. 2d 706.

376. The Canadian Medical Association, *Code of Ethics*, June, 1975, Canon 5: "An ethical physician will recognize that the patient has the right to accept or reject any physician and any medical care recommended to him . . .".

377. The American Hospital Association has recognized the right of refusal of treatment in its Patients' Bill of Rights. See, Crane, Diana "Physicians' Attitudes Toward the Treatment of Critically Ill Patients" 23(8) *Bioscience*, 471 (1973), at 474.

378. "About Death and Dying, Part 3" 5 *Nursing '75* 10 (1975).

379. A past president of the American Medical Association has stated that "[a] person has the right to refuse therapeutic measures and may elect to go without therapy to himself, regardless of the consequences and regardless of the convictions of competent physicians". Shindell, s. 193 *Journal of the American Medical Association* 1108 (1965).

380. Raible, Jane, "The Right to Refuse Treatment and Natural Death Legislation" 5(4) *Medico-Legal News* 6 (Fall 1977) at 7.

381. Mayrand, Albert, *supra*, note 233; Kouri, Robert P. "Blood Transfusions, Jehovah's Witnesses and the Rule of Inviolability of the Human Body" *supra*, note 144, Somerville, *supra*, note 293.

382. For a more thorough analysis of these mechanisms, see Kennedy, *supra*, note 356; Crane, *supra*, note 377, at 472; Roth, *supra*, note 352.

383. *Ibid.*

384. *Ibid.*; see also *supra*, note 356.

385. *Murray v. McMurchy*, *supra*, note 375; *Natanson v. Kline et al.* 350 P. 2d 1093.

386. *Humphries v. O'Connor* (1864) 17 Ir. C.L.R. 1 at 7; *On the Matter of Charles Osborne* (1972) 294 A. 2d 372; Glazebrook *supra*, note 253, at 99; Kennedy, *supra*, note 356, at 222. This presumption is questioned on historical grounds by Binavince, Emilio S., "The Ethical Foundation of Criminal Liability" 33 *Fordham Law Review* 1 (1964) at 6.

387. Shapiro, Barry B., "Legal Aspects of Unauthorized but Necessary Emergency Treatment" (1963) *Law Society of Upper Canada Special Lectures* 255 at 257.

388. See, for example, *Penitentiary Act*, R.S.C. 1970, c. P-6, section 18 and various provincial public health statutes.

389. See, for example, *Criminal Code*, sections 234, 465; Code Civil Procedure, S.Qué. 1965, c. 80.

390. See, for example, workmen's compensation legislation in the provinces.

391. This is the accepted standard for both criminal and civil negligence, although liability for criminal negligence is founded on recklessness and a high degree of derogation from the customary practice. For discussion

of the civil standard, see: Linden, Allen M., *Canadian Negligence Law*, 56 (1972); King, Joseph H., "In Search of a Standard of Care for the Medical Profession: The 'Accepted Practice' Formula" 33 *Vanderbilt* Law Review 1213 (1975); *Wilson v. Swanson* [1956] S.C.R. 804; *Dale v. Munthalia*, 1(3) *Legal Medical Quarterly* 234 (1977).

392. Nathan, Lord, *Medical Negligence* 24 (1957); Sherman, Irvin "The Standard of Care in Malpractice Cases" 4 *Osgoode Hall Law Journal* 222 (1966) at 223; Jolowicz, *Winfield and Jolowicz on Tort*, *supra*, note 27, at 61; *Stakes v. Guest, Keen and Nettlefold (Bolts and Nuts) Ltd.* [1968] 1 W.L.R. 1776.

393. *Wilson v. Swanson*, *supra*, note 391, at 817; Linden, *Canadian Negligence Law*, *supra*, note 391, at 44; Sherman, *ibid.*, at 230.

394. King, *supra*, note 391, at 1236.

395. *Criminal Code*, section 198. This exception appeared in Canada's first *Criminal Code*, 1899 (55-56 Vict. c. 29), section 212 which was identical to article 306 of Stephen, *Digest of the Criminal Law*, *supra*, note 36.

396. *R. v. Webb*, *supra*, note 137; *R. v. Simpson*, *supra*, note 218; *Halsbury's Laws of England*, Vol. 26 (3rd ed.), "Medicine and Pharmacy: Criminal Liability".

397. Emergency Medical Aid Act, 5 Nfld. 1971, No. 15; Medical Act, 5 Nfld. 1974, No. 119, s. 28; Medical Act, S.N.S. 1969, c. 15, s. 38; Emergency Medical Aid Act, S.S. 1976, c. 17; Emergency Medical Aid Act, S.A. 1974, c. 122.

398. Henderson, Gordon F. and Fisk, George E., "The Legal Position of a Doctor in Treating Accident Victims" (1976) *Chitty's Law Journal* 224 (September) at 226. Note, however, that there are no reported cases where a medical doctor has been sued for negligence in the rendering of emergency treatment (Linden, *supra*, note 391, at 16,20).

399. *Supra*, note 115.

400. The cases to 1850 favoured the Hale/Blackstone view that the bona fide and honest exercise of one's best care and skill count not result in manslaughter unless there was gross ignorance or inattention (*R. v. Williamson* (1807) 3 C. & P. 635; *Commonwealth v. Thomson* (1809) 6 Mass. 134; *R. v. Van Butchell*, *supra*, note 115; *R. v. St. John Long* (1830) 4 C. & P. 398; *R. v. Webb*, *supra*, note 137; *Rice v. State* (1844) 8 Mo. 561). However, dicta in *R. v. Spiller*, *supra*, note 119 (1832) had suggested that merely want of "competent skill and sufficient attention" would found a conviction for manslaughter. Later American and British cases tended to support the approach in the *Spiller* dicta (*March v. Davison* 9 Paige 587; *State v. Hardister* (1882) 42 Am. Rep. 5; *R. v. Burdee* (1916) 12 Cr. App. R. 153, 25 Cox C.C. 598, 115 L.T. 904; *Barrow v. State* (1920) 188 Pac. 351). The basis of the approach was expressed by the following comment of the court in *March v. Davison*: "Our statute does indeed prohibit persons not authorized by law from practicing physic or surgery in this State (New York). And as the person who should attempt to practice contrary to the statute would be engaged in an unlawful act, he could not probably escape a conviction of man-

slaughter if he should kill a patient, even where he supposed the remedy was not dangerous to health or life." For a statement of the nature of this later line of reasoning as strict liability, see Turner, *Russell on Crime*, *supra*, note 37, at 462 (ftnt. 18).

401. *R. v. Rogers*, *supra*, note 119.

402. *R. v. Sault Ste. Marie*, *supra*, note 282, at 40 per Dickson J.; Laskin J.A. (as he then was) in *R. v. Maurantonio* (1967) 65 D.L.R. (2d) 674 at 675 (in dissent) said:

> . . . it is only [the accused's] lack of professional qualifications that can be put against him as affording ground for conviction of [indecent assault]. As I interpret the law, this is not enough.

403. For a general discussion of crimes, public welfare offences, and strict liability, see Law Reform Commission of Canada, *Our Criminal Law*, *supra*, note 3: Law Reform Commission of Canada, *Studies on Strict Liability*, Ottawa, 1974; Jobson, "Far From Clear" 18 *Criminal Law Quarterly* 294 (1975-76); Perkins, "The Civil Offence" 100 *University of Pennsylvania Law Review* 832 (1952); Hall, "Principles of Criminal Law" [1947] Chancery 13; Sayre, "Public Welfare Offences" 33 *Columbia Law Review* 55 (1933). Also, *R. v. Sault Ste. Marie*, *ibid.*

404. *Morgentaler v. R.*, *supra*, note 12, per Laskin C.J. at 650; *R. v. Bourne*, *supra*, note 13; *R. v. Bergmann & Ferguson* in 1 *British Medical Journal* 1008 (1948) and in Dickens, *Abortion and the Law*, *supra*, note 14 at 50.

405. In *R. v. Machekequonabe*, *supra*, note 286, a conviction for manslaughter was obtained where an Indian, believing a shadowy figure to be an evil spirit, shot at the "spirit" and killed his father-in-law. See Trescher and O'Neill, "Medical-Care for Dependent Children: Manslaughter Liability of the Christian Scientist" *supra*, note 287.

406. The threat posed by minority religious groups is both different from and smaller than that posed by the ordinary criminal. The danger is limited in scope to those included in the sect and their families; and it is not wantonly applied to the general public. It is doubtful whether criminal punishment on this basis restores the status quo, nor deters similar action in the future. See Larson, Robert Keith "Child Neglect in the Exercise of Religious Freedom" 32 *Chicago-Kent Law Review* 283 (1954); Trescher and O'Neill, *supra*, note 287.

407. The *Universal Declaration of Human Rights*, Article 25, *supra*, note 9.

408. For a thorough discussion of the national health insurance, see Andreopoulos, Spyros (ed.), *National Health Insurance: Can We Learn From Canada?* (1975). The principle of the right of access to health services has been declared in Canada by the then Minister of Health, Marc Lalonde in Perpich, Joseph G. (ed.), *Implications of Guaranteeing Medical Care*, 118 (1975). The only province to actually declare a "right" to health services is Québec (Act Respecting Health Services and Social Services, S.Q. 1971, c. 48, s. 4). Ontario, for example provides mandatory legislation that health services must be available to all residents

of the province (Province of Ontario, *Report of Health Planning Task Force*, (1974)).

409. For example, the Family Law Reform Act, S.O. 1978, c. 2, s. 15, 16 and 17 creates an obligation of spouses to support spouses, parents to support children, and children to support parents; The Penitentiary Act, R.S.C. 1970, c. P-6 and Regulation 2.06 provides that "Every inmate shall be provided, in accordance with directives, with the essential medical and dental care that he requires."

410. Stephen, *Digest of the Criminal Law*, *supra*, note 36, at 217, article 305 & 306.

411. For example, provincial Public Health Acts provide for special arrangements in case of infectious diseases, the care of eyes of the newborn, and tuberculosis, to name only a few circumstances.

412. See, for example, Public Health Regulations, R.R.O. 1970, Reg. 721 dealing with x-ray safety; Food and Drugs Act, R.S.C. c. F-27 and amendments; Narcotic Control Act, R.S.C., C. N-1 and amendments.

413. This possibility will be discussed futher by the Law Reform Commission of Canada in *Cessation of Treatment*, *supra*, note 366.

414. Hale, 1 *Pleas of the Crown* 429; Holdsworth, *A History of English Law* (Vol. 2) 51; Binavince, "The Ethical Foundation of Criminal Liability", *supra*, note 386, at 10. Hale has said:

> [It] cannot come under the judgment of felony, because no external act of violence was offered, whereof the common law can take notice, and secret things belong to God . . .

415. As Binavince, *ibid.*, pointed out,

> the proposal of Bentham and his American disciple, Edward Livingstone, to create liability based on omission was rejected in preference to the established rule as supported by Lord Macaulay and Stephen.

416. Henderson and Fisk, *supra*, note 398, at 225.

417. *Charter of Human Rights and Freedoms*, S.Q. 1975, c. 6, s. 2:

> Every human being whose life is in peril has a right to assistance. Every person must come to the aid of anyone whose life is in peril, either personally or calling for aid, by giving him the necessary and immediate physical assistance, unless it involves danger to himself or a third person, or he has another valid reason.

418. Binavince, *supra*, note 386: The *Alternative Draft of a Penal Code for the Federal Republic of Germany*, (1977) recommends narrowing of the duty to exclude danger to property. It does, however, include danger to limb and not only life.

419. Vermont Statutes Ann., Tit. 12, s. 519(a) (1973); Massachusetts (regulations).

420. *Act to Promote Good Citizenship*, S.Q. 1977, c. 7.

421. *Supra*, note 397.

422. Medical Act, S.N.S. 1969, c. 15, s. 37(i); Medical Act, S.Q. 1973, c. 46, s. 41(b); Health Disciplines Act, S.O. 1974, c. 47, s. 52(2); Medical Act, S.M. 1964, c. 29, s. 3; Medical Profession Act, R.S.S. 1965, c. 303, s. 70; Medical Profession Act, S.A. 1975, c. 26, s. 66(c); Medical Act, R.S.B.C. 1960, c. 239, s. 72.

423. *R. v. St. Germain*, *supra*, note 26.

424. *Horsley v. MacLaren* [1969] 2 O.R. 137, [1970] 2 O.R. 487, aff'd 22 D.L.R. 545; Stewart, James, "Torts: Negligence: Duty of Care to a Boat Passenger: Duty Owed to a Rescuer: *Horsley v. MacLaren*, [1970] 2 Ont. 487" *Ottawa Law Review* 325 (Summer 1970).

425. *Bourgeois v. Dade Country*, (1957) 99 So. 2d 575; *New Biloxi Hospital v. Frazier*, (1962) 146 So. 2d 882; *O'Neill v. Montefiore Hospital* (1960) 11 App. Div. 2d 132, 202 N.Y.S. 2d 436; *Methodist Hospital v. Ball* (1961) 362 S.W. 2d 475; *Wilmington General Hospital v. Manlove* (1961) 174 A. 2d 135; see Copeland, Charles Gregory, "Liability of Private Hospital Emergency Rooms for Refusal to Provide Emergency Care" 45 *Mississippi Law Journal* 1003 (1974).

426. Canadian Medical Association, *Code of Ethics*, June, 1975, "Responsibilities to the Patient", s. 11, 12.

427. *Ibid.*, s. 12, 13; International Code of Medical Ethics provides:

> A doctor must give the necessary treatment in an emergency, unless he is assured that it can and will be given by others.

428. Shindell, "Legal and Ethical Problems in the Provision of Medical Care: Ethical Standards and Societal Norms" 37 *Yale Journal of Biology and Medicine*, 379, (April 1965) at 386; Henderson and Fisk, *supra*, note 398, at 224; Annas, George J. "Beyond the Good Samaritan: Should Doctors Be Required to Provide Essential Services?" *Hastings Centre Report*, 16 (April 1978).

429. Order-in-Council, Executive Council Chamber, Québec, October 6, 1971, *Québec Official Gazette*, Nov. 6, 1971, Vol. 103, No. 45, 8091; Annas, "Beyond the Good Samaritan . . .." *ibid.*, at 17.

430. Henderson and Fisk, *supra*, note 398; Wright and Linden, *Canadian Tort Law*, *supra*, note 123, at 326-330. Gray, J. R. and Sharpe, G. S., "Doctors, Samaritans and the Accident Victim; (1973) 11(1) *Osgoode Hall Law Journal* 1 (June). Gray and Sharpe favour a positive duty to render emergency assistance. See also Manitoba Law Reform Commission, Report no. 11 "*The Advisability of a Good Samaritan Law*", in which such a law was not recommended.

431. Gusfield, Joseph "Social Sources of Levites and Samaritans" in *The Good Samaritan and the Law* (1966).

432. Universal Declaration of Human Rights, Article 1:

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

433. This is true except for Newfoundland, New Brunswick and Prince Edward Island.

Law Reform Commission of Canada
Commission de reforme du droit du Canada

PROTECTION OF LIFE

medical treatment and criminal law

Working Paper 26